EXHIBIT E

01

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
AT CHARLESTON

RE: ETHICON, INC, PELVIC, REPAIR SYSTEM PRODUCTS REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION	)	Master File No. 2:12-MD-02327 JOSEPH R. GOODWIN U.S. DISTRICT JUDGE
THIS DOCUMENT RELATES TO THE FOLLOWING CASES IN THE WAVE 1 OF MDL 200:		
CHARLENE LOGAN TAYLOR,	)	Case No. 2:12-cv-00376
Plaintiffs,	)	
vs.	)	
ETHICON, INC., ET AL.,	)	
Defendants.	)	

VIDEOTAPED DEPOSITION OF NATHAN W. GOODYEAR, M.D.

March 3, 2016
3:50 p.m. to 7:39 p.m.

TRACY IMAGING
KNOXVILLE, TENNESSEE

Michele Faconti, RPR, LCR (667)

APPEARANCES OF COUNSEL

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Also Present: Ernie Tracy, Videographer

INDEX OF EXAMINATION

INDEX TO EXHIBITS

INDEX TO EXHIBITS

STIPULATION

The deposition of Nathan W. Goodyear, M.D., called as a witness by the Defendants, pursuant to all applicable rules of the 3rd day of March, 2016, at the offices of Tracy Imaging, Knoxville, Tennessee, before Michele Faconti, RPR, Licensed Court Reporter and Notary Public in and for the State of Tennessee.

It being agreed that Michele Faconti, a Tennessee Licensed Court Reporter, may report the deposition in machine shorthand, afterwards reducing the same to typewritten form. All objections, except as to the form of the question, are reserved to on or before the hearing.

It being further agreed that all formalities as to notice, caption, certificate, transmission, etcetera, are expressly waived, EXCLUDING the reading of the completed deposition by the witness, and the signature of the witness.

(03:50 P.M.)

VIDEOGRAPHER: We are on the record. Today's date is March 3rd, 2016.

My name is Ernie Tracy, I'm the videographer for Golkow Technologies.

The time is 3:50 p.m. And this is in the matter of Taylor v. Ethicon.

The deponent today is Dr. Nathan Goodyear, M.D. And the attorneys will now identify themselves for the record.

MS. MOORE: Kim Moore on behalf of the defendants.

MS. CAPODICE: Cami Capodice on behalf of the defendants.

MS. KOTT: Mikalia Kott on behalf of the plaintiffs Charlene Taylor and Tina Morrow, Dina Bennett and Teri Shively.

MR. KOTT: My name is Joseph Kott. I represent the same plaintiffs identified by my Colleague moments ago.

WHEREUPON,

Nathan W. Goodyear, M.D.,

having been first duly sworn, as hereinafter certified, testified as follows:

DR. GOODYEAR: I do.

EXAMINATION

BY MS. MOORE:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. As I previously introduced myself, I'm Kim Moore. I'm here on behalf of the defendants. Going to ask you some additional questions about your care and treatment of the plaintiff, Charlene Logan Taylor.

And let me just say as a side, I know we spent time together this morning going over your background sections and discussing all that testimony. I am going to do my best not to retread any of that territory. There may be a few things that we go into by the virtue of your opinions in each case. We'll try to do our best to streamline things. I know we have time left -- I have three hours in this deposition.

MS. MOORE: Is that correct, Counsel?

MR. KOTT: I think that's correct.

MS. MOORE: I used three, got three left for each case.

MR. KOTT: You don't have to use all of

it.

MS. MOORE: I understand.

BY MS. MOORE:

Q. We'll begin with the attachment of Exhibit No. 33, which is a document I know you're a little familiar with, and that is the Notice of Deposition. And we spent some time this morning talking about the attachment that is accompanying that particular request.

And safe to say that your responses that you gave us for that particular Notice of Deposition in Mrs. Shively's case are the same responses that you have in this case?

A. Correct.

Q. Now, we did identify -- or you identified some documents that I believe would be responsive to the request for medicals in Ms. Taylor's case?

A. Can you recollect my memory?

Q. Sure. Do you have a binder there for Ms. Taylor? I think you had a binder of medical for Taylor. This right there, sir?

A. Right here.

Q. Take your time and just let me see if that is correct.

A. Exhibit No. 7?

Q. Yes. Take your time and look at that and if you'll identify that for the record?

A. This is Exhibit No. 7.

Q. We discussed how that particular binder has medical records pertaining to Ms. Taylor, but does not have the medical bills; is that fair to say?

A. That is fair to say.

Q. And one of the other items that we discussed earlier would be correspondence -- any and all correspondence or emails or any type of communication pertaining to the Taylor case. My understanding is you have some emails with the Herman Firm, and those will be produced --

MR. KOTT: Well, those will be considered for production.

MS. MOORE: We're going to request that those be produced. On the next break make sure we talk about that. Because I would want to knock that out tomorrow, so we don't have to come up here for another deposition, if the Court so determined that that was appropriate.

BY MS. MOORE:

Q. We'll discuss that, you don't need to worry about that right now, Doctor. But with respect to Ms. Taylor, are there any other documents that you have in your possession that we have not already covered today?

A. Everything that I have is right here.

Q. Thank you. I think you mentioned earlier that you have an independent recollection of Ms. Taylor?

A. Well, the first deposition was with regards to Mrs. Shively.

Q. Mrs. Shively. Yes. And I thought -- well, do you have an independent recollection of Ms. Taylor?

A. Vaguely.

Q. And what does that mean?

A. Very little.

Q. And what do you remember about her?

A. Basically the memory is basically jogged by what I see in the medical records.

Q. Fair enough. My records indicate that the first time you saw her was actually June of 2008, and the exact date is June 18th, 2008. Do you have

that visit, sir?

A. I do.

Q. And what I'd like to do is, however you take me through, the history that she gave you on that visit. She's 54 years old?

A. That is correct.

Q. She had complaints of fatigue, waking up feeling tired, lack of motivation?

A. Correct.

Q. You commented that she's there concerning malaise and fatigue, and the fatigue is moderate?

A. Correct.

Q. All right. And then you do a review of symptoms and you find again just positive for fatigue, night sweats, and unintentional weight gain?

A. Correct.

Q. Where is her weight? I do notice down under objective -- oh, I see it. Pardon me. Under objective she's 69 inches tall, 281 pounds and her BMI is 41.5?

A. That's correct.

Q. And how would you characterize her BMI?

A. Morbid obesity.

Q. Back up to your assessment of her symptoms she -- gastrointestinal. She's positive for constipation?

A. Correct.

Q. No abdominal pain. Acid reflux, nausea, vomiting. Genitourinary: She has no lesions, hematuria, menstrual problems, polyuria, abnormal vaginal bleeding, and vaginal discharge?

A. Correct. Just a review of symptoms.

Q. And then she has some -- looks like some musculoskeletal complaints?

A. Yes.

Q. With respect to her gynecological history, you want to tell us what was significant there? She's pregnant twice with two children, vaginal deliveries?

A. Correct.

Q. And so at this point, you do a Pap smear and you find or diagnose a small fissure of the right labia majora. And then you diagnose -- in the vagina you diagnose rectocele and enterocele. And she does not have a uterus, right?

A. That is correct.

Q. She's had a hysterectomy?

A. That's correct.

Q. Do you have anything in your records indicating when she had a hysterectomy?

A. Under surgical history it says at age 26.

Q. All right. Do you have any additional records that would indicate the cause of some of her musculoskeletal problems? Did you have any additional information at that time?

A. I did not.

Q. I would like to turn now to your expert report that we have previously marked. We are about to mark. And that's going to be No. 38?

MS. MOORE: Let's go off the record for a minute.

VIDEOGRAPHER: The time is 15:58.

(Off the record.)

VIDEOGRAPHER: It's 4:00 o'clock.

(Exhibit No. 38 marked.)

BY MS. MOORE:

Q. Exhibit No. 38, Doctor, has been marked as your Rule 26 Expert Report, and in Ms. Taylor's matter. And I'd like to turn your attention to the second page. And you reference in -- under clinical summary, patient first seen on 6/18/2008. That's

what we were discussing just a moment ago, correct?

A. Correct.

Q. You say patient was initially seen for fatigue, weight gain, constipation. You have discussed all those things that were in your note, correct?

A. Correct.

Q. And then you say stress urinary incontinence. I did not see a diagnosis of stress urinary incontinence on that particular visit in June of 2008?

A. That is correct.

Q. Okay. So can we just take that out, there was no diagnosis of it at that point in time?

A. At that time, no.

Q. All right. Now, as in the other cases -- strike that.

As in Mrs. Shively's case or -- have you had a chance to review the deposition of the plaintiff in this case, Ms. Taylor?

A. Ms. Charlene Taylor, I have not.

Q. And have you reviewed the deposition of the plaintiff in any of these cases?

A. I have not.

Q. So would it surprise you if Ms. Taylor testified that she did not have any pelvic or gynecological problems until you did a pelvic exam on her?

MR. KOTT: Objection.

THE WITNESS: I haven't seen that if that's her testimony.

BY MS. MOORE:

Q. Pardon?

A. I haven't seen that, if that's her testimony.

Q. So if she did not have symptoms of any pelvic or stress urinary incontinence problems at the time she first saw you --

A. Constipation.

Q. She had constipation. But she did not have any other problems, correct, based on your records?

A. Correct.

Q. Is constipation a common finding for -- in your patients' population?

A. It's a common finding for most.

Q. And why is that? Just due to diet or number of factors?

A. There's a lot of different causes.

Q. Could you tell the ladies and gentlemen of the jury some of the factors for constipation?

A. For example in this case, prolapse particularly of rectocele or enterocele, especially of this degree. Dehydration, so not enough fluid intake. Not enough fiber intake, i.e. vegetables, fruit, etcetera.

Q. Did you detect any prolapse on this visit?

A. I did.

Q. And where is that?

A. That is under exams. Genitourinary. When you come in on a small fissure of the right labia major and it said rectocele, enterocele.

Q. All right. Thank you. And the cervix is absent. Uterus absent. Okay. Thank you.

Did she have any -- do you believe the constipation was a symptom of the rectocele or the enterocele?

A. Yes.

Q. Which one?

A. Both.

Q. Any other symptoms of the rectocele or the enterocele?

A. That she had that was related to it?
Q. Yes, sir, on that particular visit.
A. No.
Q. It looks like she returns back to see you. There are a couple of visits. I'm not going to go through each and every one of them, but I will go through the ones that are a little more detailed.
So let's turn now to July 15th, 2008.
A. Okay.
Q. And, again, there's the history and physical. Chronic constipation, splinting required for evacuation, pelvic pressure and pain noted. What -- would you explain -- what is splinting required for evacuation, what does that mean?
A. Because she had a very large enterocele and rectocele, basically what happens is the Valsalva pressures instead of pushing the feces out the anus, it actually goes into the weakness of the rectocele, enterocele, protruding thus into the vagina since it's the path of least resistance. So with splinting what's required is where they have to actually push up inside the vagina to offset that.
Q. Now, this is something we really haven't touched on, but this condition, these rectoceles,

this enterocele prolapse. They are types of prolapses?

A. Correct.

Q. For women, of course?

A. Correct.

Q. And they would be under the umbrella of pelvic organ prolapse?

A. Correct.

Q. And these types of conditions can be serious conditions for women, would that be fair to say?

A. They can.

Q. And in some instances they can be life altering?

A. Yes.

Q. And in an instance like this where a woman has to actually use her hand to assist in having a bowel movement, that would be pretty severe?

A. Yes.

Q. And throughout your practice, have you seen other instances where pelvic organ prolapse has affected a woman's ability to have an enjoyable life?

A. Yes.

Q. And could you tell the ladies and gentlemen of the jury some examples?

A. The pressure. Pelvic pressure, particularly with standing, ambulation, walking, etcetera. So standing up all day with your work, the pressure there. Other issues would be related to the chronic constipation and the bloating, etcetera, that accompanies that, because of the inappropriate movement of the feces. There can be issues related to pain that radiates down the leg, into the labia. There can also be pain with intercourse that goes along with that.

Q. And could you also have just embarrassment issues, altering or affecting how you interact or perceive yourself in social settings?

A. Yes.

Q. And problems with sexual relations with a spouse or a partner?

A. I gather it could be.

Q. When you say -- I'm just trying to understand from your perspective.

A. Yes.

Q. And I, obviously, don't want to go into specifics of your patients, other than, of course,

what we are talking about with Ms. Taylor.

A. It wouldn't necessarily make intercourse impossible, it would just make it less pleasant.

Q. And for some women when you have an organ prolapsing, it can alter their feelings about participating and enjoying sexual activities?

A. You're asking me to jump into somebody's head, but I can see how that would be possible.

Q. Right. I don't want you to do that. I just want you to speak to what you know from your experience treating women with these types of conditions.

A. It affects them emotional.

Q. That's what I was trying to understand.

A. Yes.

Q. And why?

A. Because -- usually it's because of their ability to relate to being a woman in a sexual relationship.

Q. And the same type of question with respect to stress urinary incontinence, can that affect a woman's ability to lead a normal life?

A. They can lead a normal life with stress urinary incontinence, yes. A lot of women do.

Q. And are there some women who it interferes with their ability to lead a normal life?

A. Yes.

Q. And can you based on your -- do you have any experiences or in your experience, do women lead normal lives with stress urinary incontinence?

A. They can lead a normal functional life. It's a quality of life issue.

Q. Okay. And what do you mean by "quality of life issue"?

A. For example, whether they would be comfortable wearing a pad with jogging or not. That's obviously not going to be conducive to an early mortality, but it's a quality issue as it relates to having to wear a pad because of exercise.

Q. Are there some women in your experience who are hesitant to go out in public because of the concerns of having urinary issues, stress urinary incontinence, or other urinary issues?

A. I don't know that's stretching it to going out in public, but maybe limiting certain activities.

Q. Such as?

A. Such as making sure they don't drink a lot

before they go walking. A lot of water. It doesn't inhibit them from walking, but they make sure they don't drink a lot of water before they go out.

Q. Have you had instances where patients have described to you accidents that they have had in public?

A. Yes.

Q. That's embarrassing, correct?

A. Yes.

Q. It can be?

A. Yes.

Q. Going back to your office visit on July 15th of 2008. You talked about in your records; that is, that she has a medical history for depression, hypothyroidism, and sleep apnea?

A. Yeah, that's what she told us.

Q. And she was taking an antidepressant. One of her stressors -- recent stressors was work?

A. Looking for the medication list.

Q. I think this is under medical history. Got it? This is before gastrointestinal.

A. Is this back on the initial visit?

Q. The July 15th, 2008. After the history and physical where it talks about the depression.

A. Yeah, I see the past medical history, but you referenced the medications.

Q. Not the specifics, but she's taking the antidepressant. It doesn't give a specific.

A. Yes, I see it. Sure, she's taking an antidepressant, yes.

Q. And her most recent stressor at that time was her work?

A. Yes, that's what she stated.

Q. And, again, under the gastrointestinal section, she's positive for constipation, correct?

A. That is correct.

Q. And then genitourinary, what did you find that -- there's negatives there, what did you find that was significant there?

A. I found that she had polyuria, so frequency during the day.

Q. What does that mean, for the ladies and gentlemen of the jury?

A. She was peeing a lot. Not volume, but frequency.

Q. Meaning constantly having to go to the bathroom?

A. Yes.

Q. And she had some abnormal vaginal bleeding and vaginal discharge?

A. She had some blood in her urine. She had some vaginal bleeding and some vaginal discharge, that is correct.

Q. What causes vaginal bleeding?

A. There can be a wide spectrum. She's had a fissure, so that's the most likely cause in that clinical finding.

Q. Anything else in a postmenopausal woman?

A. There could be atrophic vaginitis. There could be vaginal cancer. There could be postmenopausal uterine bleeding. There could be coming from a bladder infection. Could be coming from a wide spectrum in that area.

Q. And the discharge, what do you believe is causing her vaginal discharge here?

A. I did not comment on what I thought it was, so just noted vaginal discharge.

Q. What causes a vaginal discharge in woman like Mr. Taylor?

A. Usually it's a bacterial imbalance.

Q. For the ladies and gentlemen of the jury, that would be some kind of infection?

A. Not necessarily, no.

Q. All right. Can you describe what a bacterial imbalance is then?

A. There is normal bacteria in the vagina and there is a normal balance that we are aware of via through the literature, and they can become imbalanced. Say via antibiotics.

Q. Did you have an opinion at this point in time what may have caused Ms. Taylor's vaginal discharge?

A. I did not.

Q. Is that something that's common, you see vaginal discharge in women?

A. Yes. It's common throughout the normal cycle of a menstruating woman, yes.

Q. How about a postmenopausal woman?

A. It can be also present, yes.

Q. Can it also be common?

A. I guess it depends on how you define it, yes.

Q. How do you define "yes"?

A. Common.

Q. Okay. Is it something that you frequently see?

A. Yes.

Q. Looks like you did an exam next. And this is something I did not quite understand, and I wanted you to take us through, pelvic organ prolapse, stage three. What -- how do you -- is that a grading system, staging, phasing system; and if so, could you explain that for us?

A. The POP-Q system is basically agreed upon by ICS, AUS, SGS.

Q. And those organizations are?

A. International Continence Society. The American Urogynecological Society and the Society for Gynecological Surgeons.

Q. And are you a member of those organizations?

A. I'm not currently.

Q. And why is that?

A. Because I no longer practice pelvic -- gynecological, pelvic organ prolapse, urinary incontinence.

Q. Now, these pelvic -- take me through pelvic organ prolapse and how would you stage a prolapse?

A. Do you want me to go through the entire

exam?

Q. If it's possible, yes. Thank you.

A. So come into the examination room with a nurse. Have them get up on the bed, lie supine.

Q. Lie supine?

A. Flat on your back. Then I would first examine her belly. Okay. So feel for any masses. Any tenderness. Listen to her belly. Listen for any, you know, hypo-functioning bowel sounds. Look for any type of issues there.

Then I would let her know that I'm now going to examine her vulva. So I would let her know that I'm putting on gloves and I'm going to touch her. So first thing I'm going to do is examine her external vulva. The labia majora, labia minora. And then her anus, just be a visual inspection. Then I would ask her when was the last time you voided. And then I would have her cough and bear down. At that point then what I would do, is would measure her total vaginal length. I would insert a speculum so as to inspect the cervic, the vaginal walls, anterior, posteriorly. Then I would proceed to a bi-manual exam. Where I would then insert my right hand, because I'm right-handed, to manipulate

the cervix. My left hand would be on the fundus of the uterus, that would allow me to feel the fallopian tubes, the ovaries, as well to evaluate her pelvic floor for any asymmetries or obvious defects.

At that point if I had discovered prolapse of any degree, I would then proceed with a POP-Q examination. Which is basically a measured system to objectively measure the degree of prolapse and the location of the prolapse. So at that point I would focus on the anterior measurements, which would be AA and BA, and CC. Which would be cervix. Okay. And those measurements, as agreed upon by those organizations, is basically from the hymen, the vaginal opening. Then at that point, I would also measure the posterior measurements. A and B as well. And also if they had a cervic, D would be included in here. But according to this, D is negative, meaning there was no cervic. And also measuring the general hiatus, which is from the middle aspect of the urethra opening to the posterior fourchette, which is the posterior aspect of the vaginal opening. And then the perineal body, which goes from that posterior fourchette, or

vaginal opening, back down to the middle aspect of the anus. And then the total vaginal length was already determined at that point. I would then document that point.

I would change gloves and I would then move to do a rectal. So I put on new gloves so as to palpate for any rectal defects, via digital exam. I would also assess the tone of the external and internal anal sphincter defect.

Q. What is that?

A. The external and internal anal sphincter muscle complex. For which we did the endoanal ultrasound, if you remember.

Q. Yes.

A. And at that point then I would change gloves, and then I would actually perform the same exam with her standing up so as to assess the pressures of the vulva standing up and to see for the difference objectively between laying and standing.

Q. And based on that examination, your findings for Ms. Taylor were what?

A. That she had a stage three enterocele, rectocele with a prolonged perineal body

measurement.

Q. I wasn't quite sure -- the prolonged perineal body measurement, what is the significance of prolonged perineal body measurement, if any?

A. Well, for her she's got enterocele, rectocele, so her proximal connected tissue attachments to the cervic has allowed -- think of it as a pendulum. It has allowed her perineal body, which should only be about three, to basically prolong because of the anterior detachment and so it prolongs. So the vagina will move down and get stretched. And so the perineal body gets stretched. Or the perineal body measurement gets stretched. But the detachment is proximal in the vagina.

Q. What's the significance of a stage three finding of an enterocele and rectocele?

A. It's simply based on the number evaluation finding on the POP-Q.

Q. So there's a stage one through --

A. Two, three, and four.

Q. And four being most severe?

A. Four being complete avulsion.

Q. Complete avulsion?

A. Yes.

Q. Are there any type of recommendations for when surgery would be recommended? For example, with a stage three, do you automatically have surgery or is that at stage two or does it vary according to the patient?

A. It varies according to the patient. Their symptoms that are associated.

Q. So you look for the pelvic organ prolapse stage plus symptoms?

A. Correct.

Q. And what kind of symptoms do you look for?

A. For stage -- as you progress --

Q. The trigger to the point where you would say to a patient like Ms. Taylor, "I think you need surgery and here's why"?

A. The mere presence of the symptoms. Also understand sometimes the prolapse is so severe that the symptoms actually are no longer there because nerves damaged.

Q. And what -- you said the "mere presence of symptoms," what symptoms are you referring to, just having them would be enough for you to say to your patient, "I really think you need surgery"?

A. Just the mere presence of the symptoms

shows that the prolapse is, indeed, symptomatic.

Q. But I'm trying to find out what the symptoms are.

A. For her it's constipation. Constipation -- the splinting required for evacuation, the pelvic pressure, and pain.

Q. And -- okay. So you look at the symptoms of the patient, plus their pelvic organ prolapse stage in determining what advice or recommendations you would make to a patient?

A. Yes.

Q. Continuing on that same date looking at the genitourinary. And it looks like everything is normal. You have vagina atrophic mucosa. What is that?

A. Atrophic mucosa?

Q. Yes, sir.

A. It is a thinning of the vaginal wall.

Q. And what causes that?

A. Classically low estrogen.

Q. And what causes that?

A. Classically postmenopausal state.

Q. And what can a woman do to -- first of all, is that problematic? Does that present any

type of symptoms when your vagina -- atrophic means what? Drying up? Shrinking?

A. It's dry. The vaginal tissue is typically a very moist tissue, and it's typically very dry. It lacks rogation, which is the folds, becomes very thin and flat.

Q. So the mucosa is the layer --

A. The vaginal mucosa, yes, the layer you see visibly.

Q. That you would see, the doctor?

A. Correct.

Q. But that layer is somehow --

A. It just doesn't look as healthy.

Q. And aside from just a physical, is there a quality, it's changed, it's deteriorating in some capacity?

A. For some clients it would be, for some no.

Q. Okay. So you say, "vagina atrophic mucosa mild"; is that right?

A. Yes.

Q. All right. So that -- and what kind of problems can you have if you have atrophic vagina?

A. Typically they may complain of some irritation. Vaginal dryness is a classic symptom

complaint.

Q. Can you have pain with sexual relations, with intercourse?

A. It can. It's usually with more severe forms, but it can occur.

Q. That's also, I think we said at one point, that's also known as dyspareunia?

A. That's the medical term, yes.

Q. Then you go on and you talk about rectocele, enterocele, and you have diagrams below. Would you tell the ladies and gentlemen of the jury what is a rectocele and what is an enterocele and where is that in the body? We talked a little bit about pelvic organs and the pelvic organ floor, what's happening here when you see these conditions?

A. When you look at the pelvis, you basically -- the vagina, excuse me, you're looking at, just imagine, basically two walls. On top of the wall would be the bladder. You have the top of the wall of the vagina. The vaginal space. The posterior wall of the vagina. And then behind it the rectum. Okay. And so rectocele is reference to the rectum, which is the most distal portion of the colon, which is actually a reservoir for holding until removal or

elimination at an opportune time socially.

Q. You mean a bowel movement?

A. Exactly. An enterocele is reference to more of the upper -- above the rectum, colon prolapsing down in. Okay. So we are talking two anatomical events occurring in the same general vicinity.

Q. And what causes this?

A. Enterocele and rectocele. There's typically fascial injuries. There can be issues related to birth. It can be simply related to genetics, aging. There can be issues related to surgery.

Q. So how common is it to have pelvic organ prolapse for women in their menopausal age?

A. Well, probably -- it's a hard question to answer. Because a lot of women have it and symptomatically they don't know they have it.

Q. Or a lot of women have it and live with it?

A. Yeah, they don't know it's a problem so they live with.

Q. Or they live with it?

A. That's possible, yes.

Q. So based on your knowledge, how significant is this as a problem for that particular patient population, women of a menopausal age?

A. It can be a big issue.

Q. How predominant?

A. I'd say 30, 40 percent.

Q. All right. You have drawn a diagram here for us, and if you could explain your diagram? I think it's what you took us through a few minutes ago. I'm looking at your expert -- I apologize. I am looking at your office visit record on July 15th, 2008. Do you see that?

A. I know what I'm looking for, but I'm just not seeing it in here.

Q. I can give you a copy. While we are looking for that, do you see on that record another section talking about vaginal enterocele and you're discussing future testing, cystoscopy and urodynamics?

A. In plan?

Q. Yes. And you talk about counseling, risk factors?

A. Yes. Testing in office for cystoscopy.

Q. The counseling risk factors; female,

causation, genetics, multiparity, postmenopausal age, obstetrical injury, prior pelvic surgery. What's the significance of that finding, counseling risk factors, what does that mean?

A. It's really just helping to identify causation or causes.

Q. For the problems -- bless you -- she was having?

A. Yes.

Q. The number of children you have can play a factor in pelvic organ prolapse in some women?

A. It can, but prolapse can occur for women who have never been pregnant.

Q. And does the type of delivery you have play a factor, a vaginal versus forceps or versus cesarean?

A. Again, it can. The more operative vaginal delivery, the more risk.

Q. More operative meaning?

A. Vacuum, forceps, etcetera. The more opportunity there is for damage.

Q. Because damage to the pelvic organ floor can weaken the tissues that can lead to prolapse?

A. Correct.

Q. Let's go down to July 31st, 2008. It's a quick -- strike that.

I just want to focus in quickly on the assessment. Looks like she showed up for urodynamics?

A. That's correct.

Q. And there were findings of abnormal voiding. I could not read all of that. Marginal -- something marginal flow. Do you see that? And then, of course, your diagnosis; retention, prolonged voiding phase, obstructive voiding.

A. Where are you looking?

Q. I am on -- it's probably the report of the urodynamic report, I apologize.

A. Oh, okay.

Q. Yeah, I'm going to go back to that in a minute, hold that. I was jumping ahead to the actual report, which I think was the basis of your assessment in your July 31st, 2008 report.

A. Okay. The POP-Q, I don't see that.

Q. Here you go, Doctor, you're free to look at whatever you would like. I just want to focus on the findings and the diagnosis.

MS. MOORE: Here you go?

MR. KOTT: Thanks.

BY MS. MOORE:

Q. Ready?

A. Yeah.

Q. All right. What were the findings?

A. Findings were leak point pressure of zero. Max flow rate of 11.8 mils per second. Maximum attrition (sic) pressure at max flow, 18 centimeters per water. Maximum attrition pressure 28 centimeters of water. Voided volume, 306. Residual bladder volume, 105 out to nine ccs. Urethra pressure measurement was 53 centimeters of water. Mean functional length, 65 millimeters. In incontinent area, 244 millimeters of water. Diagnosis, marginal attrition pressure. Marginal flow. Obstructive voiding. Diagnosis, retention to prolong voiding phase. Three, obstructive voiding.

Q. And based on that urodynamic clinical report, you took that into account in your assessment of Ms. Taylor on that same date, July 31st, 2008, correct?

A. Correct.

Q. And your findings; female stress incontinence, vaginal enterocele -- enterocele,

female stress incontinence; is that correct?

A. That's correct.

Q. Let's keep going. Looks like you're doing a cystostomy about a week later, August 8th, 2008.

Would you tell the ladies and gentlemen, what is a cystostomy?

A. A cystostomy is using a scope like you would with a laparoscope to actually go up inside, although it's much smaller, into the bladder through the urethra to visualize the bladder and the urethra.

Q. And based on your findings, you diagnosed again female stress incontinence and she also had a Vitamin D deficiency?

A. Vitamin D deficiency was with a blood draw, so not determined by the cystoscopy.

Q. August 12th, she returns?

A. Correct.

Q. And she's -- looks like she's there for uro and cysto results?

A. Correct.

Q. She's still having polyuria, abnormal bleeding, and vaginal discharge?

A. Correct. Symptoms, they hadn't changed.

No new symptoms.

Q. So continuing?

A. Yes, continues.

Q. Your plan at this point was you gave her extensive counseling on options. It looks like you talked about the etiology of incontinence. What is the etiology of incontinence, what causes it. And you talked to her also about the expected progression, treatment options, and types of incontinence.

A. Etiology is getting to the causation, what caused or has led to the causes of the incontinence.

Q. And in her instance, what did you believe was the etiology or the cause of her incontinence?

A. Her hysterectomy, her two vaginal births, her postmenopausal state, her weight.

Q. All of those are factors in causing incontinence because they are putting pressure on the pelvic floor?

A. They all contribute to it.

Q. What was your expected progression for Ms. Taylor, that it could get worse?

A. Yes.

Q. And why is that, because as you age you

kind of get weak -- your tissue becomes weaker?

A. Correct.

Q. So you discussed with her options and types of incontinence?

A. Yes.

Q. Greater than 50 percent of your time was spent in face-to-face counseling?

A. Correct. Yeah, because when you talk about causation, you will often be questioned.

Q. And that's an important part, having that face-to-face opportunity -- face-to-face discussion with a patient and having a chance to answer the questions, correct?

A. Correct.

Q. Bladder physiology discussed. What does that mean? Just the actual anatomy and how it works?

A. The functional aspect related to her findings.

Q. And then you go into preoperative plan. And so you had a detailed discussion of risk for treating her stress incontinence?

A. Correct.

Q. And you were discussing with her on this

particular visit an option of having surgery with mesh and particularly with a TVT-O, correct?

A. Yes. As part of the sling, yes.

(Exhibit No. 39 marked.)

BY MS. MOORE:

Q. And the risks that you discussed is outlined here in your office visit. And I want to mark this particular visit, August 12th, 2008, as Exhibit No. 39. And the risk that you discussed on that particular day include; infection, hemorrhage, blood product transfusions, 3 to 5 percent erosion risk, failure of reconstructive support, damage to bladder or bowel, excursion of graft, graft infection, death, conversion to a laparotomy, de novo urinary irritative voiding symptoms. And VTE risks. Failure of urinary retention. Those were the risks?

A. Correct.

Q. And these risks that you discussed with Ms. Taylor were risks that you knew based on various sources, including your own experience, training, and what you received from I think other sources, correct?

A. Correct. Including Ethicon.

Q. Including Ethicon. Now, I believe earlier you referenced --

A. Excuse me, again.

MR. KOTT: The exhibits are to your left, if you have to look through that stack.

MS. MOORE: Bear with me one moment. Let's go off the record for a second.

VIDEOGRAPHER: Sure. We're going off. It's 4:39.

(Off the record.)

VIDEOGRAPHER: We are back on the record. The time is 4:50 p.m.

(Exhibit No. 40 marked.)

BY MS. MOORE:

Q. All right. Doctor, earlier when being questioned about the 3 to 5 percent erosion risk listed in your counseling sessions with your patients, including Ms. Taylor, you referenced a particular study. I'm going to hand you what I've marked as Deposition Exhibit No. 40. Please feel to look at whatever you would like, and then I'm going to point you in the direction of page 48.

Where is my yellow tab?

MR. KOTT: Do we get one?

MS. KOTT: You don't have another copy?

MS. MOORE: Give me a minute and I'll give it to you. Hold on.

MR. KOTT: If I could get a copy of that. Off the record.

MS. MOORE: Know what we can do, just to keep going -- go off the record.

VIDEOGRAPHER: Hang on.

(Off-the-record.)

VIDEOGRAPHER: Go right ahead. 16:52. Excuse me 4:52.

BY MS. MOORE:

Q. Doctor, we will discuss in a few minutes your information -- the information you had with respect to the erosion risks you discussed with Ms. Taylor.

With respect to the other risks that you discussed with her, these are risks that you knew from your surgical training, your experience as a doctor and from the literature and from discussions with colleagues and from your meetings and sessions with the Ethicon team?

A. Correct.

Q. The risks that are outlined in this report

of August 12th, 2008, I think I marked as exhibit -- I did hand you a copy of that, Doctor, I apologize?

A. Of what?

Q. August 12th, 2008.

A. Yes.

Q. All right. And that exhibit is exhibit number --

A. No. 38.

Q. The risks that are listed, and that we have discussed on a couple of patients, are risks that you would also see with non-mesh surgery; is that correct?

A. Some of them.

Q. Well, let's go through them. In fact, you can see in any other kind of surgery, correct?

A. Correct.

Q. Hemorrhage, bleeding?

A. Correct.

Q. Blood product transfusions?

A. Correct.

Q. We'll talk in detail about the percentage of erosion, but isn't it correct that erosions are seen with other types of surgeries involving cadaver, porcine, or sutures?

A. This is particular to the synthetic mesh here so --

Q. I understand the percentages, but the concept of erosion occurring?

A. Anything foreign, yes.

Q. Pardon?

A. Anything foreign implanted, yes.

Q. Absolutely. So that's something that could occur with other surgeries?

A. Correct.

Q. Failure of constructive support. With or without mesh, you can have the failure of the support?

A. Correct.

Q. Damage to the bladder or bowel. You can have that with any surgery in that area, correct?

A. Correct.

Q. Extrusion of the graft. You can have that with cadaver, porcine, or other grafts?

A. Correct.

Q. Graft infections, you can certainly have that with cadaver or all types of grafts, correct?

A. Correct.

Q. Death unfortunately is seen across the

board, and can be seen with any type of surgery, including non-mesh surgeries?

A. Correct.

Q. Conversion to a laparotomy?

A. Correct.

Q. Also seen with those surgeries?

A. Correct.

Q. The de novo urinary irritant voiding symptoms. That can occur just as a result of surgery in that area, correct?

A. Correct.

Q. And so the jury understands, that when you're in that area doing surgery on a woman, there are potential risks that can occur and one of them would be de novo urinary irritative voiding symptoms. What does that term mean, de novo?

A. New.

Q. So you were making sure that Ms. Taylor were aware of all these risks, including a VTE, could happen anytime you do surgery?

A. Correct.

Q. And a failure of urinary retention?

A. Correct.

Q. So these are risks that are seen and well

known to you long before you did surgery on Ms. Taylor or any of the other -- or even Mrs. Shively, correct?

A. Correct.

Q. And, in fact, if -- I think these -- not only did you go in great detail through the risks with her on August 12th, 2008, it looks like you took her through a very detailed consent process with the Prolift, with the TVT-O, and what you called a mesh consent?

MS. KOTT: I'm sorry. I think you did said Shively just now. I just want to be clear who we are talking about, which, good luck.

BY MS. MOORE:

Q. So the record is clear, I was referring to Ms. Taylor. And I want to make sure that I'm referencing the consent that Dr. Goodyear went through with Ms. Taylor on August 12th, 2008 regarding the Prolift, in TVT-O, and the mesh.

MS. MOORE: And thank you, Counsel.

MS. KOTT: Thank you.

BY MS. MOORE:

Q. My question is, you have specific consents for the Prolift and the TVT, why did you also go the

extra step and have a mesh consent?

A. That was under guidance from Ethicon.

Q. Ethicon recommended that?

A. Yes.

Q. And where is that? Meaning where is -- is there some type of report that you received saying it's important to have mesh consent?

A. No.

Q. Tell me about that, I need to understand.

A. When I created these operative risk assessments, I then gave them to an Ethicon rep to oversee and make sure I was not -- I was stating the risks appropriately.

Q. So you gave --

A. And that's when they recommended there be one for each.

(Exhibits No. 41, No. 42 and No. 43 marked.)

BY MS. MOORE:

Q. Okay. And I'm going to hand you what I have identified as Exhibit No. 42, 43 -- 41 pertaining to Ms. Taylor. And ask you to take a look at that. Counsel, we'll get you that.

A. Excuse me?

Q. And give you a moment to look at those.
A. Yes.
Q. So, Doctor, you testified that you gave these -- all three consents or just the mesh consent you gave to Ethicon?
A. These were all given to the patient, but yes, when I created these, I wanted -- I gave them to the rep to basically look at and say, "Yes, that's correct."
Q. And who is the rep?
A. I can't remember his name.
Q. So when did this happen, because we did not talk about this earlier today?
A. This would have been in Louisiana, so whoever the rep was in Louisiana.
Q. So you did not do that with Mrs. Shively, you just did this with Ms. Taylor?
A. No, these are all uniform.
Q. And this morning when I asked you details about the consent, you did not --
A. Yeah. You did not ask about it.
Q. I asked you about -- well, I asked you in detail about conversations with any rep.
A. But you did not ask me the generation of

this consent form.

Q. And I asked you in detail about conversations with a rep. So why don't you just take us through --

MR. KOTT: Object to form.

BY MS. MOORE:

Q. -- the rep that you spoke to.

MR. KOTT: Go ahead. Do the best you can.

THE WITNESS: Just created the consent form per my training, experience, education, etcetera, and the guidance by Ethicon. And I then handed it to the rep to just read over real quick to make sure it was appropriate. That's fine or changes.

BY MS. MOORE:

Q. What did the rep change?

A. No changes. "Is this okay? Does this meet what you guys taught me so that I do not overstate?" And that's fine. And that's what was happening.

Q. So you wanted to make sure that you were telling your patients not what you knew, but what Ethicon was saying?

MR. KOTT: Object to the form.

THE WITNESS: As I said, I used my experience, my education, the training and then get his eyes on it, as well.

BY MS. MOORE:

Q. And who is this mysterious rep that's appeared?

MR. KOTT: Hold on a second. Object to the form.

BY MS. MOORE:

Q. Who is the rep?

A. I don't remember his name.

Q. What did he look like?

A. I can't remember.

Q. You can't give us any description of him?

A. Probably dressed different different days.

Q. I'm sorry?

A. He probably dressed different different days.

Q. Of course, I would hope he would, but --

A. I can't recall what he looked like. That was 2008.

Q. You have no recollection of him or his name, but you do recall --

A. I have a vague recollection in the

operating room, my office, where he is coming after me after a Bard rep comes in, he says, "You're not going to use their product, are you?" Why would I have a recollection of who this is?

Q. Describe him, please.

A. I can't describe him.

Q. Can't describe him?

A. No.

Q. You can't describe him, you don't know his name, but you do remember that he took the time to look very carefully over these consent forms?

MR. KOTT: Object to the form.

THE WITNESS: Absolutely.

BY MS. MOORE:

Q. Okay. And were there changes he made?

A. I don't recall that.

Q. You don't recall that, either?

A. No.

Q. Anything else that you recall?

A. As it relates to --

Q. Well, let's think long and hard on these consent forms. I want to make sure we don't go through this again.

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. Is there anything else that you haven't told me with respect to the preparation of your consent forms?

A. No.

Q. Okay. So the record is clear -- and you're under oath, right?

A. Yes.

Q. And you haven't had a discussion with your Counsel on a break about the consent forms?

A. No.

Q. You haven't had a discussion during lunch about the consent forms?

A. No.

Q. So we are going to make sure we are on the same page.

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. You have these consent forms here that you created based on your experience and training, correct?

A. Correct.

Q. And in your experience and training, you were seeing erosion rates close to 15 to 20 percent,

correct?

A. I told you that was the erosion rate that I was seeing when I was at the conference.

Q. Yes. That was six months before 2007?

A. That was in --

MR. KOTT: Objection.

THE WITNESS: The conference was in 2007.

BY MS. MOORE:

Q. Okay. Sometime in 2007 or before, six months or so, you started seeing erosion rates of 15 to 20 percent?

A. In that ballpark, yes.

Q. Well now, is it in that ballpark or is it 15 to 20 percent? Earlier it was 15 to 20?

A. You asked me if I've done a study on it.

MR. KOTT: Objection. Argumentative. Interrupting the witness. Not permitting him to answer. Please get control. I know it's late and we are tired. Please let him finish his answer. Please don't interrupt.

THE WITNESS: You asked for an estimate, and that's what I gave you.

BY MS. MOORE:

Q. So it's 15 to 20?

A. Yes.

Q. I just want to make sure. You want to think about it for a moment?

MR. KOTT: Objection. Commentary.

BY MS. MOORE:

Q. Fifteen to 20 percent, that's what we are going with?

A. Yes.

Q. All right. So you have this erosion rate that you have seen, and you were at a conference and you -- not only did you discuss this, but you were raising this with some other colleagues to Ethicon?

A. I did not raise it to Ethicon. I raised it to the colleague sitting next to me.

Q. And what did they say?

MR. KOTT: Object to the form. He said "colleague." "They" is plural. "Colleague" is singular.

BY MS. MOORE:

Q. I think the record will reflect he said colleagues on many occasions. But if you'd like to correct that now, please. Was it a colleague or --

A. The colleague sitting next to me.

Q. So now it's one colleague.

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. Well, let's just be clear. Is it one colleague or colleagues?

A. The specific conversation I remember having was the colleague next to my left. But as conversations typically go, one conversation joins two, joins three.

Q. Okay. So does that mean -- what does that -- help me out here. What does that mean? One, two or three conversations with three different people or three different conversations with one colleague to your left?

A. This was a round table, which means it was meant for discussion.

Q. And that helps. Now we are at a round table and we are discussing erosion rates, is that what you're saying?

A. No, that's what you're leaning to what we are saying.

Q. You tell me, you're at a round table, explain. You're at a round table and what happened?

A. I've answered you already and you mislead what I said.

Q. Try again so that we can understand. Your answers are a little confusing.

A. No. I say it once and you don't like it so you ask it again.

Q. I'm going to move to strike the comments, Counsel. I'm here to ask the questions and you may not like them, but that doesn't give you the right to make those kind of comments.

A. They don't bother me.

Q. Well, you are on video.

A. That's fine.

MR. KOTT: So are you. You're being recorded, you should think about that.

MS. MOORE: I am absolutely fine with my recording.

THE WITNESS: I'm smiling.

BY MS. MOORE:

Q. I can tell. Thank you. The round table. You're at a round table and at the round table are you discussing erosion?

A. I will describe it for you.

Q. Please.

A. There's a professor standing. There's a horseshoe. There's a colleague to my left. The

professor that is discussing complications of the Prolift mentions the erosion rate he's, again, in the middle of the midst of the horseshoe. Talks about his erosion rate. I lean to the colleague next to me and say, "Wow, that's much lower than anything I've ever seen, let alone mine." And he goes, "Me, too."

Q. So any other discussions with any other colleagues about erosion rates?

A. That's the specific discussion I remember.

Q. Do you remember the colleague's name?

A. No, I don't.

Q. Do you remember the name of any colleague sitting at the round table?

A. Colleagues, no. I do remember the lecturer, Dr. Lucente.

Q. You remember the lecturer?

A. Dr. Lucente.

Q. So he was the one that presented and said that the erosion rates were what, 3 to 5 percent?

A. No. He mentioned his percentage was less than 1 percent.

Q. Okay. So if we asked Dr. Lucente, and asked the other participants there, he would say

that the erosion rate he spoke of on that day was less than 1 percent?

MR. KOTT: Object to the form. How would he know what he's going to say?

THE WITNESS: I don't know what he will say.

BY MS. MOORE:

Q. I'm asking you what he said.

A. I'm telling you what I remember.

Q. And what you remember is he said that his erosion rates were less than 1 percent?

A. Yeah.

Q. And despite your experience being different, and your colleague to the left being different, you deferred your medical judgment and told your patients it was what Ethicon said?

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. Is that fair?

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. Because if I'm wrong, let me know.

A. I did not defer my judgment.

Q. Well, whose judgment is here?

MR. KOTT: Hold on. Please don't interrupt the witness. My goodness.

MS. MOORE: You don't need to raise your voice.

MR. KOTT: That's so basic.

MS. MOORE: You don't need to raise your voice. That's so basic.

MR. KOTT: It's so basic to let him finish his answer. I'm sorry, I will not raise my voice.

MS. MOORE: I agree. And I apologize if I interrupted.

MR. KOTT: Thank you. And I apologize if I raised my voice.

BY MS. MOORE:

Q. Start over.

A. There is no study that shows the same erosion rate, the same number of erosions, the same complications. They each present different erosion rates, that's why your training, the education, your experience, the multitude of the journal articles involved help you to create a range.

Q. Thank you. And it was based on that information that you put three to five percent?

A. Yes.

Q. So that wasn't -- the three to five percent that you have warned your patients about was not based upon your own experience, but what you had gathered from others; is that fair to say?

A. Again, I said it was with my experience, my education, the reading of the journals, along with the other education, experts, etcetera.

Q. All right. And so was your experience three to five percent or 15 to 20 percent? Because what did you put anything other than your experience in a warning to a patient?

MR. KOTT: Objection to the form.

THE WITNESS: Ma'am, I told you when I presented these consent forms, I wanted to present them as accurate as possible to my clients. And these were given to the Ethicon rep to say, "yep, that is correct."

BY MS. MOORE:

Q. And you defer to an Ethicon rep -- is the Ethicon rep a doctor?

A. No.

Q. You're going to let that Ethicon rep

proceed your judgment on the risks for erosion that you're going to tell a patient?

MR. KOTT: Objection to form.

THE WITNESS: He did not change anything. My review of the literature and my expertise and the training by Ethicon and the recommendations by Ethicon was to put those numbers there. And that's what I did. I did not pull those numbers out of thin air.

BY MS. MOORE:

Q. Where are the numbers?

A. There are numbers in every study that's different.

Q. And I appreciate that, sir. But where -- can you point to anything? Because everything you showed us, where is one document showing 3 to 5 percent, name one?

A. Okay. The document that was brought up in cross examination, which is the hysterectomy, 1 to 6 percent. Reduces the erosion rate to 1 to 6 percent.

Q. Let's talk about that for a second. Okay. We'll pull that document out. First -- so the record is clear, while we are getting that, why

wouldn't you pick a set of numbers and include the upper and lower limits when warning your patients? Why wouldn't you -- instead of going 3 to 5, why wouldn't you say 3 to 20 --

MR. KOTT: Objection.

BY MS. MOORE:

Q. -- if that's what you're hearing?

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. Because that would have captured your experience and what you're hearing from Ethicon, and as you said the numbers were all over the place, right?

A. I did not hear 20.

Q. I thought you said your experience was 15 to 20?

A. I said mine was, but I did not hear that.

Q. Okay. It's more important what you know in your experience or what you're told by others?

MR. KOTT: Objection to the form.

THE WITNESS: Everything collectively together to make sound judgment.

BY MS. MOORE:

Q. And you believe now you made sound

judgment?

A. I do. On the information I had available from Ethicon at the time, based on the studies that they provided to us.

Q. Okay. You're going to defer to a sales rep for approval of a patient consent form?

MR. KOTT: Object to form. Repetitive.

THE WITNESS: I said I did not defer to him.

BY MS. MOORE:

Q. But you asked for his approval?

MR. KOTT: Object to the form.

THE WITNESS: I asked for him to look it over and make sure that the writings I had there was accurate.

BY MS. MOORE:

Q. You had the final say, though, didn't you, sir?

A. Yes.

Q. You're the doctor?

A. Yes.

Q. The buck stops with you?

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. You're the captain of the ship?

MR. KOTT: Stop this. Object to the form. There's no captain of the ship theory of law in this state at this point in time.

BY MS. MOORE:

Q. Who practices medicine in your practice? I mean --

A. Can you rephrase the question?

Q. No. I'll withdraw the question.

Ethicon was not the only source that you had, so why did you defer to just to that source? You talked about all these sources, and yet you deferred to just one, why?

A. I didn't say I just deferred to just one. You're saying that I would just defer to one study. I did not defer to one study. I did not defer to one expert. I did not defer to one rep. I did not defer to one surgical procedure, experience or residency.

Q. All right. Here we go. Let's go first to I believe I hand -- did we give this to them yet?

If you will look at what we previously marked as No. 40. And, sir, if you will turn --

A. I don't have this.
Q. You don't have No. 40? If you want to take a moment to look at it?
MR. KOTT: Better go off the record, if you want to conserve your time.
MS. MOORE: Thank you.
MR. KOTT: You want to reference a page? If you did already, I forget what it was.
MS. MOORE: I think I'm focusing on page --
MR. KOTT: Page 48?
MS. MOORE: Yes, sir.
MR. KOTT: These things cut both ways, these documents. No. 48. Page 48.
How much time do we have left?
VIDEOGRAPHER: An hour and 20 minutes.
MR. KOTT: An hour and 20 minutes. Okay.
THE WITNESS: Are you waiting on me?
BY MS. MOORE:
Q. We are back on the record.
And, Doctor, I believe you had an opportunity to look at what we have marked as Exhibit No. 40. Turn to page 48 on the mesh exposure operation.

Now, when I was asking you questions earlier about the basis for your opinion of the 3 to 5 percent erosion risk, you referenced this particular study. And I want to make sure what in the study would support your recommendation to your patients of warning them about a 3 to 5 percent erosion risk?

A. Again, this was one reference. You asked me for a reference, you were particularly talking about the TVM. This was one reference to meet that.

Q. I'm asking for any reference at all that you have with respect to 3 to 5 percent erosion risk.

A. But you're implying that this is the only reference I'm making.

Q. I'm sorry. Please tell me all the references, I'm sorry.

A. The references we have included.

Q. Where are they? Okay. We'll go through that in a minute. But this was one you specifically looked at, and you said this supported your statement that Ethicon provided you information showing that the erosion risk was 3 to 5 percent. And I'm asking you, we have the document in front of

us, where does it say that?

A. It doesn't say 3 to 5 percent.

Q. All right. Now, do we need to go off record and let you look at the reference list? I'm looking for that document. So if you want to go off record, take a few moments to look through your reference list?

A. Okay.

MS. MOORE: Let's go off the record.

VIDEOGRAPHER: The time is 5:19.

(Off the record.)

VIDEOGRAPHER: Okay. We are back on the record. The time is 5:21.

BY MS. MOORE:

Q. And, Doctor, I'm going to ask you to look through the reference list, and not your Counsel.

A. Understood.

Q. Okay. So --

A. One thing when you average these four together, it's 4 percent.

Q. Okay. That's fine. But you have 3 to 5 in your consent. And --

A. 1 to 6 percent was per that other one we referenced.

Q. Let's look at that one then. That's in the monograph, if you want to pull that, I believe it's exhibit --

MR. KOTT: It should be in the exhibit pile marked.

MS. MOORE: I believe you're right.

MS. CAPODICE: It's No. 17.

MR. KOTT: It's No. 17.

MS. MOORE: Seems like a lifetime ago, doesn't it? Let's turn to that reference.

MS. KOTT: Page eight.

BY MS. MOORE:

Q. You have a good memory. Let's look at that sentence, it says, "Experience and avoiding hysterectomy when possible will reduce the rate to 1 to 6 percent." So this -- strike that. I apologize. Let me begin.

The paragraph is, "This is to be contrasted with the known occurrence of simple vaginal mesh exposure. It occurs in approximately 3 to 17 percent of cases. Experience and avoiding hysterectomy when possible will reduce the erosion rate to 1 to 6 percent." So that's a specific subpopulation, correct?

A. It means if you do it at the time of a hysterectomy, it expands your risk. If you do it not at the time of hysterectomy, it's more.

Q. Right. And that's a subpopulation? We are not talking about that. You weren't doing a hysterectomy --

MR. KOTT: Object to the form.

THE WITNESS: It's saying when a hysterectomy is not done or has been done.

BY MS. MOORE:

Q. It's a subpopulation, correct? "Experience and avoiding hysterectomy when possible will reduce the rate to 1 to 6 percent," correct?

A. Yeah, if she had already had a hysterectomy.

Q. And that's the population, right?

A. That she's in the 1 to 6 percent.

Q. And if you look at -- how come you're willing to accept that, but the sentence right before says, "it occurs in approximately 3 to 17 percent of cases"? 3 to 17 is overall?

A. That's a wide range. 3 to 5 percent is what I quoted.

Q. Sir, have you heard of cherrypicking?

MR. KOTT: Object to the form.

THE WITNESS: I've heard of the term, yes.

BY MS. MOORE:

Q. You have information here that was available to you before you did surgeries on the patients at issue today, correct?

A. Does not 3 to 5 percent fit in both of those?

Q. Sir, this information was available to you before you did surgery on the patients?

A. Correct.

Q. You had the opportunity to review the monograph?

A. Correct.

Q. And the document that you had in your possession, that you read says under, "Mesh Complications: Erosion, Exposure and Extrusion. This is to be contrasted with the known occurrence of simple vaginal mesh exposure. It occurs in approximately 3 to 17 percent of cases," correct?

A. That's --

MR. KOTT: When you say correct, you mean, "Am I reading it correctly?"

MS. MOORE: Yes.

BY MS. MOORE:

Q. Am I reading that correctly?

A. Yes, you are reading that correctly.

Q. "Experience and avoiding hysterectomy when possible will reduce the rate to 1 to 6 percent," correct?

A. That is correct as you read it.

Q. And you chose -- you selected only what fit your theory; and not again, the complete picture, correct?

MR. KOTT: Objection.

THE WITNESS: No. Not theory --

BY MS. MOORE:

Q. Why did you reference 1 to 6 and not 3 to 17? That was closer to your experience. 3 to 17 is closer to 15 to 20, which is your experience.

MR. KOTT: Objection.

BY MS. MOORE:

Q. Wouldn't it be safer to tell a patient a higher potential risk than a lower? Why were you saying the lower risk?

MR. KOTT: Objection. You're asking compound questions now.

THE WITNESS: And, again, as I told you,

this is one reference for many that go into the generation of this range.

BY MS. MOORE:

Q. And where are the other references?

MS. MOORE: Off the record.

VIDEOGRAPHER: Okay. We are going off. The time is 5:25.

(Off the record.)

VIDEOGRAPHER: We are back on the record. The time is 5:26.

BY MS. MOORE:

Q. Doctor, earlier you testified that the representation to your patients of a 3 to 5 percent erosion risk came from information you received from Ethicon, correct?

A. In addition and as a part. In addition, there were journals, articles, that were included in that as well.

Q. Okay. So now it wasn't solely from Ethicon?

A. I didn't say that.

Q. Oh. So what information came from Ethicon? The information that we just referenced in the monogram?

A. That was one part of the studies and information that I used to bring together my opinion.

Q. So that was one part, anything else from Ethicon?

A. As I told you, I also then wrote it, and just to make sure that the literature supported what I was writing there, got the eyes of the rep.

Q. Okay. But I want to know, is there anything else on your reference list or that you have relied on from Ethicon that would support your representation to patients of an erosion risk of 3 to 5 percent?

A. What's listed here is the studies that I used to generate that.

Q. So if it's -- strike that.

As you sit here today, though, you can't point to anything else on your list?

MR. KOTT: Other than what he's already pointed to?

BY MS. MOORE:

Q. Other than the monograph. And then you referenced this -- let me make sure I understand. You referenced what we marked as --

A. The TVM study.

Q. -- Exhibit No. 40. And then that particular study, Doctor, you said that the average number here is 6. But you can't average, because they are not the same samples, correct?

A. Some are actually lower.

Q. So you're mixing the populations here and choosing to interpret this to your benefit?

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. Would you say that the discussions you have -- the informed consent discussions that you have are important discussions with patients?

A. Yes.

Q. And especially in light of accusations that you've had in the past of not giving proper consent?

MR. KOTT: Object to the form.

THE WITNESS: You did not finish.

BY MS. MOORE:

Q. With the background -- with your experience of being sued for not giving -- for a patient not having appropriate consent?

A. I don't know where you're coming up with

that.

Q. You don't? Well, because you went through a lawsuit where it was alleged that the patient did not have appropriate consent, and there was a surgery that occurred. Do you remember that?

MR. KOTT: Object to the form.

THE WITNESS: I think that was clear enough I didn't give the consent. I didn't do the surgery. I was named because I was in the operating room.

BY MS. MOORE:

Q. I understand that's what you're saying now. All I'm saying is that you were sued in the Complaint?

A. I'm not saying that's what happened.

Q. And that's fine, the Complaint says something else?

A. Yes, it did.

Q. And you said earlier people have a right to sue?

A. As it was brought up, there was no verdict, there was no money paid, and it ended.

Q. And there was an allegation, though, that you performed a battery on a patient because you did

surgery without an informed consent, correct?

MR. KOTT: Objection.

THE WITNESS: And proved not to be the case.

BY MS. MOORE:

Q. That's your opinion?

A. No, that's the final verdict.

Q. Well, there was an allegation, right? And we're talking today of allegations, right? You're throwing out allegations here, so I want to make sure in the informed consent process -- that's an important process, right?

MR. KOTT: Objection to the commentary, to the statements, argumentive nature of what is being purported to be questioning. So please keep that in mind and pose the question to him -- a question that he can answer as opposed to soliloquy.

BY MS. MOORE:

Q. Informed consent is a very important process with a patient, correct?

A. Correct.

Q. And if you're going to tell a patient about risks, why would you error on the low side

when your experience shows otherwise?

A. I erred on the side of --

MR. KOTT: Objection. Let him answer, please.

BY MS. MOORE:

Q. Please answer, I'm sorry. I do want to hear the answer.

A. The information available at the time is what was used.

Q. You allowed information available at the time to override your own personal experience of a higher risk?

MR. KOTT: Object to the form.

THE WITNESS: The experience includes studies, operative experience, surgical experience included. All of that is included.

BY MS. MOORE:

Q. But, Doctor, those other people weren't doing the surgery, you were doing it and it was your track record?

MR. KOTT: Objection to the soliloquy. There is no question. This is argumentative. Either put a question before him or don't respond to the soliloquy.

BY MS. MOORE:

Q. Let me ask you this. If you were having surgery, would you want the doctor to tell you what the literature report was on the success rates or the doctor's own experience?

A. I would want a wide-spectrum analysis of the risks.

Q. And if you don't, you lowballed it, how would that be?

MR. KOTT: Objection to the form.

MS. MOORE: We'll move on.

MR. KOTT: Thank you.

BY MS. MOORE:

Q. Let's keep going. Let's see. Let's turn to October 7th, 2008.

A. Okay.

Q. Looks like the patient is there for bowel prep instructions. And, again, you go through the risks again with her. Is there a reason that you felt it was necessary to go through the risks again?

A. That was probably just something we did at that point. I don't recall the relationship to that.

Q. Okay. And, again, you talked about the

same risks. And, obviously, she -- all right. It looks like the next visit -- well, there's your operation of the patient on October 21st. And you want to take a moment and look at that particular report?

A. Yes.

Q. And tell me when you please have it in front of you.

A. I have it right now.

Q. Pre-op diagnosis was a 52-year-old with stage two enterocele and rectocele. Is that what you see?

A. That's what I see.

Q. Now, I thought we saw stage three enterocele and rectocele earlier?

A. That is correct.

Q. So this is a pre -- when did it change?

A. It didn't.

Q. So help me here.

A. It's stage three.

Q. But the record says stage two?

A. Yeah.

Q. Why is that?

A. Probably a misstating in the operative

report.

Q. But it is a stage three?

A. Yes, it is.

Q. How do you know?

A. Based on the POP-Q examination.

Q. And you did a posterior Prolift and a TVT-O. Your findings, a large enterocele, rectocele, high-mid and low. What does high-mid and low mean?

A. Implying the anatomical sites of where this is occurring. So in terms of the rectocele, it's low and it's high in the rectum. And then enterocele is high posterior vaginal. It's really giving anatomical site to the posterior vagina.

Q. All right. Let's go then -- your post -- let's look at your post procedure note, 10/21/08.

A. I see November 4th.

Q. I'm looking at --

A. Operative report was 10/21.

Q. Right. And the post procedure -- bear with me one moment. Okay. Under -- do you have this copy here, sir?

A. Yes.

Q. All right. Let's look at that. This is a

post procedure note. What's a post procedure note?

A. It's a procedure note to -- it's different than the operative note, just to be simple and concise.

Q. And reporting on what took place in the surgery?

A. Yes.

Q. And that's your signature?

A. It is.

Q. And it says pre -- post procedure diagnosis, stage two enterocele and rectocele. Post procedure same?

A. Same.

Q. Same?

A. Stage two enterocele, rectocele TVT. It does say the same, yes.

Q. Right. And so was it stage two or stage three?

A. It was stage three. Stage three is plus one or higher.

Q. But you said stage two in pre-op and now in post-op you're saying -- after the surgery you're saying stage two?

A. As I mentioned, that was an error.

Because the POP-Q confirmed it's a stage three.

Q. The POP-Q was on the physical exam?

A. That's correct.

Q. Let's see go --

MR. KOTT: Are we at a point we can take five?

MS. MOORE: Of course.

VIDEOGRAPHER: We are going off the record. The time it 5:36.

(Off the record.)

VIDEOGRAPHER: We are back on the record. The time is 5:41 p.m.

BY MS. MOORE:

Q. Okay, Doctor, we are back. It's been a long day. I'm going to try to move quickly. We have gone through a lot. I'm going to try to work through the records. And I think you have them in front of you, so that should help facilitate.

Let's look quickly, obviously take as much time as you would like, but look at November 4th, 2008. And this is an office visit, follow-up visit from surgery. And it indicates under genitourinary. My question is, there was a reference of a likely hematoma?

A. There is.
Q. And what is that about?
A. It was a -- a hematoma is a collection of blood underneath.
Q. And what can cause a hematoma?
A. Operation.
Q. That's just a risk of surgery with and without mesh, correct?
A. Correct.
Q. And does it -- that's not related to the mesh surgery or to your technique?
A. I'm sorry, can you restate?
Q. Is that hematoma related to your technique?
A. No. Because my technique was as Ethicon taught.
Q. I did not understand.
A. My technique was as Ethicon taught. As, A-S.
Q. The hematoma wasn't related to your technique, because you were trained as Ethicon taught?
A. You asked me if it was my technique; and I said no, I did the technique as Ethicon taught it.

Sorry.

Q. How much does your professional judgment come in when you're treating a patient? Do you do what you think is best, or do you listen to what you have been told by others?

MR. KOTT: Objection. Asked and answered 50 times.

THE WITNESS: I'm doing what I think is best for the client at that time.

BY MS. MOORE:

Q. And so what do you think caused the hematoma in the client?

A. Related to the surgery.

Q. And can a hematoma interfere with normal healing?

A. It usually doesn't interfere, it just causes the healing to be a little more prolonged.

Q. There is literature indicating it can interfere -- indicate with normal healing, correct?

A. Yeah, it can prolong it.

Q. And it can also increase the risk of mesh exposure, correct?

A. Correct. Can increase complications.

Q. So even with adequate training things can

happen during a procedure that can lead to a hematoma, unknown risk factor, correct?

A. Correct.

Q. And even in surgery, things like hematomas can occur that can increase the risk of mesh exposure, correct?

A. Correct.

Q. Let's look at the next visit, it's 11/19/08. She appears to be doing well without any significant symptoms. You see that, sir?

A. I see 11/19. But I'm looking for the statement you made.

Q. 11/19/08. It would be under history and physical.

A. Am I missing the history on this?

Q. And it's down -- I'm sorry, top paragraph under HPI beginning with additionally. And it is the third sentence from the end, currently.

A. I go from November 4th, and I'm obviously missing that page.

Q. I'll be happy to give you a copy, and your Counsel. This is going to be Exhibit No. 44.

(Exhibit No. 44 marked.)

MR. KOTT: Thank you.

BY MS. MOORE:

Q. And this is again referenced as the November 19th, 2008 visit. And do you see where I am about, "currently, she's doing well," that's in the second paragraph under HPI?

A. I do.

Q. She's doing well without any significant effective symptoms?

A. Vaginal bleeding has stopped. Feeling much better, correct.

Q. And under genitourinary it's negative for genital lesions, hematuria, menstrual problems, polyuria, abnormal vaginal bleeding, and vaginal discharge.

MR. KOTT: The review of systems.

THE WITNESS: Okay. Review of systems. Yes, correct. I thought you were in physical exam.

BY MS. MOORE:

Q. No worries. And, Doctor, if you would look at page three of your report. So let's keep that in front of you, what we just read under symptoms, as your Counsel pointed out. And let's look at page three.

MR. KOTT: No, it was under review of systems is what Counsel pointed out.

MS. MOORE: Thank you, Counsel. Appreciate the clarification.

BY MS. MOORE:

Q. If you would turn to page three of your report. And let's look under that particular visit. Let's go down under -- it's the second paragraph -- full paragraph. The patient has complained, do you see that?

A. Page three, second paragraph. Okay. Yes.

Q. "Patient complained of persistent vaginal bleeding from the immediate post-op period following her 2008 implant surgery to current." And you're referencing exam on 11/5/15. I'm sorry. You're referencing, October 2008. Implant surgery to current. Correct?

A. Correct.

Q. And she's not having any bleeding problems on this particular visit, and as your record indicates, she hasn't had persistent vaginal bleeding from the immediate post-op following her October 2000 (sic) implant surgery to current?

A. Well, I said she had no bleeding at that

point, it had stopped.

Q. But your report indicates, does it not, that the patient has complained of persistent vaginal bleeding from the immediate post-op period from the October 2000 (sic) implant surgery to current. Is that what your report says?

A. That is correct.

Q. And is that accurate based on your own records?

A. Here at this point, there was no bleeding.

Q. But your records -- your report rather indicates persistent vaginal bleeding from immediate post-op following October 2008, implant surgery to current?

A. Correct. But when you look at Dr. Winters and you look at Dr. Galloway, you see that there was vaginal bleeding.

Q. I'm not asking about their experience. I'm asking about your care and treatment of the patient.

A. I can tell you what we are looking at right there is simply I'm saying there was no bleeding at that exam point.

Q. Well, you actually say a little bit more

than that, don't you?

A. I said vaginal bleeding had stopped.

Q. And so if there's no vaginal bleeding, it's not persistent?

A. There's no vaginal bleeding at that moment.

Q. Does that mean it's persistent? Help me out here.

MR. KOTT: Object to the form. Object to form.

MS. MOORE: I'll withdraw that question.

BY MS. MOORE:

Q. Doctor, what is persistent bleeding?

A. Persistent bleeding means regular bleeding.

Q. And she wasn't bleeding on that particular visit, was she?

A. At that visit she was not.

Q. Let's go now to December 15th, 2008.

A. Okay.

Q. You have got under genitourinary --

A. Under review of symptoms?

Q. Yeah. Genitourinary. External genitalia. Trocar sites well healed. Vagina good pelvic

support. Small exposure, probably site of hematoma.

A. No.

Q. I'm sorry, it's under physical exam.

A. Physical exam, yes.

MR. KOTT: ROS is review of systems. Okay. That's just general questions for all the body. Now, where are we? Physical exam, okay.

BY MS. MOORE:

Q. You see that?

A. Yes, I do.

Q. Okay. Probably site of hematoma, about one centimeter from the vault?

A. Yes. Correct.

Q. And so it was your belief at this point that there was some type of exposure -- a small exposure, but that was probably where the hematoma was; is that correct?

A. That's correct.

Q. And we talked about hematomas interfering with healing, correct?

A. Correct.

Q. Talked about hematomas contributing to erosions, correct?

A. Correct.

Q. Let's continue on to the -- go down to the -- let's see.

The January 13th, 2009 office visit. I'm sorry. I'll let you get that. Tell me when you're ready.

A. Yes, January 13th.

Q. I'm curious about the muscle disuse atrophy under your assessment.

A. Uh-huh.

Q. And what --

A. Where are you referencing that?

Q. Under assessment, 1/13/09, office visit. It's under procedure assessment. If you're looking at the paragraph halfway down, assessment.

A. You're talking about the procedures. Okay. Halfway down. Assessment, muscle disuse atrophy.

Q. What does that mean, what is a diagnosis of muscle disuse atrophy?

A. Means you have got declining pelvic pulled muscles.

Q. So they are weak?

A. Yes.

Q. What's the potential complication of a weak pelvic pulled muscle?

A. As it relates to?

Q. What kind of complications could one have as a result of that diagnosis?

A. You could have prolapse.

Q. And you recommended then pelvic floor therapy treatment?

A. Correct.

Q. Let's go down under -- 2/10/09?

A. 2/10/09.

Q. Okay. Ready?

A. 2/10.

Q. Yes, sir.

A. Yes.

Q. Constipation worse as of late. Prolapse is better -- doing better. Do you see that?

A. Yes, I do.

Q. Under genitourinary, negative for genital lesions, hematuria, menstrual problems, polyuria, abnormal vaginal bleeding, and vaginal discharge. So she's not having --

A. Are we in review of symptoms, HPI or exam?

Q. We are in review of symptoms.

A. Yes.
Q. And these are complaints that she, being Ms. Taylor, would have shared with you on that particular visit?
A. That is correct.
Q. And so she's telling you that she's not having any vaginal -- abnormal vaginal bleeding?
A. Correct. But she had had some previously too documented.
Q. Okay. We are talking about this particular visit. It's not persistent?
A. Not this visit.
Q. Again, it's not persistent, right?
MR. KOTT: Object to the form.
THE WITNESS: It's not present that day.
BY MS. MOORE:
Q. This is another time. We did not see it in the last visit, either? You want to go back and look at that?
MS. MOORE: Let's go off the record for a second.
VIDEOGRAPHER: Okay. We are going off. The time is 5:53.
(Off the record.)

VIDEOGRAPHER: Going back on the record. The time is 5:56.

BY MS. MOORE:

Q. Okay. Doctor, you've had an opportunity to look carefully at your notes. And isn't it correct that throughout the visits that we discussed -- I know we discussed in detail the visit on November 19th, 2008, the subsequent visits on 12/15/08, 1/6/09, 1/13/09, 1/20/09, 2/3/09 and 2/10/09, and 5/11/09, do not discuss or are negative for abnormal bleeding or vaginal discharge?

A. Well, you're throwing those numbers out there, and I'm just not going right back to them.

MS. MOORE: Let's go off the record and let you get comfortable with what I've asked.

VIDEOGRAPHER: Time is 5:57.

(Off the record.)

VIDEOGRAPHER: It's on.

BY MS. MOORE:

Q. You know what, I'm going to go off the record and just let you look at the records, because I can't eat up the time.

VIDEOGRAPHER: Sure.

(Off the record.)

VIDEOGRAPHER: We are back on the record. The time is 5:59.

BY MS. MOORE:

Q. All right. Doctor, you've had a chance to look through your records?

A. Yes.

Q. And have you seen any indication of vaginal bleeding or vaginal discharge?

A. On the dates you mentioned?

Q. Yes, sir.

A. I did not see any.

Q. And -- okay. So there's no evidence of persistent vaginal bleeding, correct?

A. Not on --

MR. KOTT: Object to the form.

THE WITNESS: Not on those dates that you mentioned.

MR. KOTT: That's the answer.

MS. MOORE: Move to strike comments of Counsel.

MR. KOTT: I move to strike it, also. I move to strike it, also. I concur with the stricken comment. What I meant by that, that is --

MS. MOORE: It sounded great, though. That's the answer.

MR. KOTT: Yes. In other words, the persistent bleeding starts later. I think it's evident.

MS. MOORE: I know it's late, and we are all tired.

MR. KOTT: You're right, I'm sorry.

THE WITNESS: Okay.

BY MS. MOORE:

Q. Let's go back on the record. And going now to 2/10/09. And at this point in time, again there's no evidence of vaginal bleeding or vaginal discharge, correct?

A. Not that's listed here.

Q. Okay. You do note a very small exposure left from the prior trimming. Easily removed. No further exposure noted. Did you trim the mesh on this visit, February 10th, 2009?

A. Correct.

Q. And this mesh that you trimmed, was this in the location of the hematoma?

A. Correct.

Q. And now you're seeing her again, a second

time on 2/10/09 for an office excision, correct?

A. I see February 10th, 2009. You said office excision?

Q. I'm asking you -- well, it's your -- under the exam. There's a very small exposure left from the prior trimming, it was removed.

A. Yeah. I thought we just went over that.

Q. February 10th, 2009. We did. Your report -- let's look at your report on that date. You talk about the patient -- I apologize. If you look at clinical summary, kind of down more than halfway in the paragraph, page two. You with me?

A. I'm with you.

Q. "Patient presented 14 months later with repeated posterior erosion, incomplete bladder emptying, urinary frequency, urinary urgency, and continued constipation with required splinting."

Where is that referenced in your records? I know we did see the constipation appearing again and we have seen some trimmings. Where is any reference to incomplete bladder emptying?

A. On the February 10th note.

Q. Well, you -- February 10th or -- let's look anytime. May 11th. I'm just trying to see

where that -- where you got that information. I've not seen that.

A. Constipation had improved.

Q. Okay. It's improving, but your report indicates she's presenting 14 months later, meaning after your October 2008 surgery, with repeat posterior erosion, incomplete bladder emptying, urinary frequency, urinary urgency, and continued constipation with required splinting.

MR. KOTT: What's that date again?

MS. MOORE: Absolutely. His report says, 14 months later from, and I believe that's referencing the October 21st, 2008 surgery.

THE WITNESS: Constipation wasn't better.

BY MS. MOORE:

Q. The constipation wasn't better?

A. No.

Q. Okay. And I did not see where it was requiring splinting?

A. Well, constipation wasn't better, so thus the splinting wouldn't have changed.

Q. Okay. That's not in your records, but you remember that?

A. Yes.

Q. Okay. And how about the incomplete bladder emptying, where is that?

A. It's right here in the clinical summary. "Patient presented 14 months later with repeated posterior erosion, incomplete bladder emptying."

Q. I see it's in your report.

A. Okay.

Q. I'm looking for the basis for that statement in your records?

A. For February 10th, it's not listed there.

Q. Is it listed on May 11th?

A. The same year?

Q. Yes, sir.

A. May 11th of 2009?

Q. Yes, sir.

MS. MOORE: And let's go off the record, just so you can take your time and --

VIDEOGRAPHER: Okay. We are going off the record. The time is 6:06.

(Off the record.)

VIDEOGRAPHER: Okay. We are back on the record. The time is 6:11 p.m.

MS. MOORE: Do we know what year we are?

VIDEOGRAPHER: You did have 50 minutes

left.

BY MS. MOORE:

Q. All right. Sir, we went on break off the record. Doctor, I'll remind you to look at your records. I was trying to understand the basis for the opinion in your report on page two that "The patient presented 14 months later with repeat posterior erosion, incomplete bladder emptying, urinary frequency and urinary urgency and continued constipation that required splinting." We have seen references to the constipation. And we talked about the posterior erosion. We'll talk a little bit more about that. But I just want to make sure I understand. What is the basis for the statement of an observation of incomplete bladder emptying, urinary frequency, and urinary urgency?

A. That would be based on urinary retention.

Q. And where is that?

A. It's not in what I reviewed here, based on my visits.

Q. And help me understand. So you're basing your opinion that Ms. Taylor was having incomplete bladder emptying, urinary frequency, urinary urgency because of urinary retention?

A. That's what would cause incomplete bladder emptying.

Q. Where is that? Did she ever tell you that was a problem she was experiencing?

A. Not in the notes where she saw me.

Q. All right. And let's first stay within your notes. You don't have any indication of those complaints, correct?

A. Not at that point, no.

Q. Well, you've taken some time to look at your records?

A. Yes.

Q. And you don't have any indication of those complaints, correct?

A. Uh-uh.

Q. Now, let's move outside of your notes. From any other information that you may have reviewed, have you seen anything in anyone else's records with respect to what you call urinary retention?

Q. You want to go off the record so you can check?

A. I had it just for a second. Yeah, please.

MS. MOORE: Off the record.

VIDEOGRAPHER: You want to go off the record?

THE WITNESS: Yeah.

VIDEOGRAPHER: We are going off. The time is 8:13 (sic).

(Off the record.)

VIDEOGRAPHER: We are back on the record. The time is 6:16.

BY MS. MOORE:

Q. All right. Doctor, I was asking you to review your records to see if you have any basis for the statement and your report about the patient, Ms. Taylor, presenting 14 months later with incomplete bladder, urinary frequency, urinary urgency. And you have been unable to locate anything in your records that would substantiate that statement, correct?

A. In my records, but additional records.

Q. In your records, correct?

A. Correct.

Q. And I know you were looking for some other records that may substantiate that?

A. Yes.

Q. And do you have something?

A. I do.
Q. You want to tell us what that is?
A. The location would have been medical center where she had hesitancy, urgency, and urinary frequency.xxxcheck25thmarch
Q. And when was that?
A. That is March 25th.
Q. What year, please?
A. 2011.
Q. 2011. So do you know what you were referencing -- you're not sure what you were referencing in this statement, correct?
A. That's not my statement. Oh, that right there?
Q. Yes, sir.
A. I'm referencing obstructive voiding symptoms.
Q. Right. And you say patient "presented 14 months later." What did you mean by "14 months later"?
A. I believe it was 14 months from the operative time.
Q. Okay. That's what I thought. And based on the records, I know you --

A. Where is that?

MS. MOORE: Go off the record.

MR. KOTT: He's just looking back.

MS. MOORE: I know, but off the record.

(Off the record.)

THE WITNESS: The way I read this is it's 14 months roughly from the seven week post-op period.

BY MS. MOORE:

Q. So -- but that wouldn't put you into 2011, would it?

A. I'm just saying that's the way I read that.

Q. I understand. And then you found a reference to a March 25th, 2011 visit, that wouldn't put you at 14 months out, right?

MR. KOTT: Out from what?

MS. MOORE: He just said he believed he was referencing seven months -- seven weeks post-op. So 14 months from seven weeks post-op, would be about 16 months from the October 21st, 2008 surgery, which would put you into about February of 2009 or so.

THE WITNESS: Right. 14 months.

MR. KOTT: Don't agree with that, think it through.

MS. MOORE: 2010.

MR. KOTT: 2010 surgery. I'm sorry. I'm very sorry. Somebody who is willing and thinks they can and state it correctly. Is there anyone here?

MS. MOORE: Wait. Joe, I have an idea.

VIDEOGRAPHER: Okay.

(Off the record.)

VIDEOGRAPHER: Back on the record.

BY MS. MOORE:

Q. Seven months -- seven weeks from 10/21/2008, would be about December 2008 and then 14 more months --

A. That would be actually seven weeks. That would be actually into January.

Q. Right. Of 2010?

A. That would be January -- seven weeks from 10/21/2008, would be January 2009. At the seven week post-op visit.

Q. Seven weeks -- well, seven weeks from October?

A. I'm sorry. December.

Q. It's February 2010?
A. December.
Q. Do you have anything that would substantiate what you meant in this particular statement in that time period?
MS. MOORE: I have to go off the record.
VIDEOGRAPHER: Sure. We are going off the record. And the time is 6:20.
(Off the record.)
VIDEOGRAPHER: Back on the record.
BY MS. MOORE:
Q. Okay. We have spent a lot of time on trying to understand the basis for your opinion that there was incomplete bladder emptying, urine frequency, and urinary urgency in the report on page two. And as we sit here today, in your records, you don't have anything that would support that, correct?
A. The visit I'm referencing is this one with Vincent Grigsby, that's the first set of symptoms.
Q. And when would those first set of symptoms be?
A. Those are 2011.
Q. That's more than 14 months or so?

A. That is correct.

Q. So the record is clear that you have symptoms that may support that, but that wasn't until what day?

A. That was March 27th, 2011.

Q. Okay. All right. Let's keep going. I think that if you can just quickly turn to 5/11/09. It looks like she's doing well, other than her weight.

A. 5/11/09?

Q. Yes, sir.

MS. MOORE: Let's go off the record.

VIDEOGRAPHER: Okay.

(Off the record.)

VIDEOGRAPHER: We are back on the record.

BY MS. MOORE:

Q. So, Doctor, 5/11/09, there's no complaints of vaginal bleeding, abnormal vaginal bleeding or vaginal discharge, correct, under genitourinary?

A. Yeah. I was just reading through my HPI too. That's correct.

Q. And she's doing well except for her weight?

A. She had gained five pounds at that point.

She still had the constipation.

Q. All right. But she was doing well?

A. Constipation and abdominal cramping.

Q. I think you -- and then August 11th, 2010.

A. Okay.

Q. It looks like there's a -- you have noticed a piece of exposed, I believe, mesh with spotting under the history and physical?

A. Correct.

Q. And that's two years post-op, posterior repair?

A. Right.

Q. And you did a -- you said there's a very -- first of all -- strike that.

You say vagina, good pelvic support?

A. Yes.

Q. So the --

A. With a small piece of mesh.

Q. Right. But you are getting the support that you needed from the Prolift at this point in time, that's documented in your records?

A. Correct.

Q. You have a small piece of the mesh, that was with us again, in the site of it -- this was in

the site of the previous post-op hematoma?

A. Correct.

Q. And so that exposure was caused by that hematoma?

MR. KOTT: Object to the form.

THE WITNESS: Exposure was a part of that hematoma increased risk.

BY MS. MOORE:

Q. I'm sorry?

A. Hematoma will increase the risk.

Q. Let's go then to your visit on -- let's see. Again on December 13th, 2010. Looks like --

A. Hold on a second.

Q. I apologize.

A. Okay.

Q. And there's another procedure. No indication of abnormal vaginal bleeding, vaginal discharge, and no mention of incomplete bladder emptying, urinary frequency or urinary urgency?

A. Correct.

Q. And there's a vaginal enterocele. Very small extrusion is vastly removed. Small area persistent, was difficult to see. This was trimmed, removed successfully?

A. That's correct.

Q. And that's in the same area we have been focusing on with the hematoma?

A. Correct.

Q. And then it appears around this time she returns back to see you, I believe -- is this the last time you see her before your examination most recently, 2/1/11?

A. I believe that's correct.

Q. Okay. And, again, at that time on 2/1/11 you don't have -- strike that.

2/1/11 she's 263 pounds, correct?

A. 2/1/11, so February 1st, 2011?

Q. Yes, sir.

A. I'm sorry, just jumping around.

MS. MOORE: Want to go off the record?

VIDEOGRAPHER: 6:29.

(Off the record.)

VIDEOGRAPHER: We are back on the record.

The time is 6:31.

BY MS. MOORE:

Q. All right. Doctor, that particular visit, I misspoke earlier, that's not your last visit, but in that particular visit, again, there's no evidence

of the Plaintiff telling you at least that she was experiencing any type of vaginal problems?

MS. KOTT: Objection. Form.

BY MS. MOORE:

Q. I mean, she doesn't have any complaints, right?

A. Yeah, that's correct.

Q. I mean she had no complaints, right?

A. That visit right there, no.

Q. So that --

A. Not related to the vaginal surgery.

Q. Right. Just concerns about her weight?

A. She had other complaints.

Q. But nothing before the vaginal surgery. So there's no evidence here of --

A. This visit was actually for a different reason, though.

Q. Nonetheless you did a genitourinary review of symptoms?

A. Correct.

Q. And she did not report any?

A. Correct.

Q. So you must have been pleased with her progress at this point?

A. At that point that's what I had, yeah.
Q. Let's go then to your visit of October of 13th, '11.
A. October 13th of 2011?
Q. Do you have that, sir?
A. No, I do not.
MS. MOORE: Let's go off the record.
VIDEOGRAPHER: We went off at 6:32.
(Off the record.)
BY MS. MOORE:
Q. And she is reporting to you in October of 2011, she was concerned about the recurrence and feels mesh. You say she had the Prolift in 2008, did well until presenting with an erosion in 2010. Splinting resolved for about two years and now this has returned. And in addition she's concerned about intercourse, correct?
A. That's how it reads, yes.
Q. Your plan, vaginal enterocele referral initiated to Dr. Pizarro in Shreveport to evaluate for mesh removal and resupport for enterocele, if needed, correct?
A. Correct.
Q. All righty. You did see the mesh -- I

think you record exam shows erosion of mesh approximately 3 to 4 centimeters posteriorly in the suture line?

A. That's how it reads, correct.

Q. Again, this is in the area where you observed the hematoma?

A. It doesn't say that.

Q. Okay. Hematoma, as you said, is a reason or can cause erosion?

MR. KOTT: Objection.

THE WITNESS: It can increase the risk of erosion.

BY MS. MOORE:

Q. And erosion is something that you knew that could occur with mesh before you did surgery with Ms. Taylor, correct?

A. Correct.

Q. Let's turn now to your office visit in November of last year?

A. November 5th?

Q. Yes.

A. I actually have that.

MS. MOORE: Mark that as 2007 -- strike that. I'm sorry.

MR. KOTT: What number are you marking it?

MS. MOORE: No. 47.

(Exhibit No. 47 marked.)

BY MS. MOORE:

Q. All right, Doctor. How did Ms. Taylor come to see you on this particular day?

A. She came to see me for review of her pelvis postoperatively.

Q. And was that at the recommendation of her Counsel?

A. It was.

Q. And you performed an exam on her?

A. I did.

Q. And what were her complaints on that day? Let's see if we can move this pretty quickly. She had some postmenopausal vaginal bleeding?

A. She said vaginal bleeding had persisted and worsened in the last two to three years. This required continuous use of pads and frequent changes. She can feel the mesh and the exposed mesh irritates her bladder and urethra. She also notices an odor with the vaginal discharge. She has noticed that the pain moved from a localized vaginal pain and intermittent to now constant pelvic inguinal

pain.

She's developed low back pain and this has now migrated down to her anterior thighs. She's not sexually active, but she didn't know it would be painful and impossible for her. She said this created sadness and she gave up in relationships, says, "Why would any man marry me?"

She also notices anxiety, worsening fatigue, worse than anything before, chills, fevers, painful walking, decline in quality of life since the mesh was inserted. Social activities and relationships have significantly declined due to the vaginal bleeding. Wears the pad continuously, pain and odor.

She defines the mesh as a negative turning point for her. She now just tries to get through the day. Bladder symptoms include emptying, frequency, and urgency. Constipation remains. Splinting still required.

Q. Okay. She had filed a lawsuit against Ethicon by this point, correct?

A. Yes.

Q. Under your history and physical, going back up, you then talk about she presents for

postmenopausal vaginal bleeding, saying it started following her surgery in October of 2008. It didn't start -- there was quite a long period of time when you treated Ms. Taylor where she had no evidence of postmenopausal bleeding, correct?

A. Correct.

Q. And we talked about the hematoma. We did not talk about the estrogen, but you had prescribed that to improve her atrophic vaginitis?

A. To improve the healing.

Q. But you say to improve the atrophic vaginitis, correct?

A. Where are you reading that?

Q. That is under your HPI.

A. Yes. That is correct. It does read that way.

Q. Okay. So you did put her on estrogen to improve the atrophic vaginitis?

A. Correct.

Q. And that, as you told us earlier, can cause abnormal bleeding and cause difficulties, painful sex?

MR. KOTT: Object to the form. You mean the estrogen or atrophic vaginitis?

THE WITNESS: Clarify, please.

BY MS. MOORE:

Q. Can estrogen cause painful sex?

A. No.

Q. Atrophic vaginitis can cause it?

A. It can.

Q. And then you talked about the suture lines and the repeated erosions. Has she had surgery with Dr. Winters?

A. To this date?

Q. Yes, sir.

A. Yes.

Q. And you have had a chance to review those reports?

A. Yes.

Q. All right. What you did -- let's see. You did an exam and tell me your findings.

A. My exam on November 5th, 2015. To genitourinary?

Q. Let's see. You noted a vaginal discharge?

A. Vaginal discharge noted. Posterior erosion noted. Seeing distally and midline. Significant granulation tissue presents along the suture line posteriorly with hard ridge in posterior

vagina. Tenderness along posterior granulation line. Tight band right arm of mesh in upper right corner of vagina, very tender to touch. No rectal erosion is palpable or palpated.

Q. Thank you. And let's take them one by one. Vaginal discharge could be caused by many things, correct, as you have discussed earlier?

A. It can.

Q. We talked about the posterior erosion that you observed on a couple of occasions and now you're seeing it again at this particular visit; is that correct?

A. Correct.

Q. You are also noting some granulation tissue?

A. Correct.

Q. We talked earlier on about the -- I think you described granulation is -- strike that.

What causes granulation?

A. It's an inflammatory healing process.

Q. Does it vary, the degree of granulation seen varies from patient to patient?

A. It does.

Q. Is it seen with and without mesh surgery?

A. It is.

Q. Can you have tenderness with and without mesh tenderness?

A. You can. Time frame here is a little bit different. The time frame is different.

Q. Well, with a complicated scenario, you can still have tenderness, correct?

A. Correct. But if there's no mesh placed, there's no source. It's just autologous tissue.

Q. What if there is scarring or fibrous tissue?

A. If there is scarring, correct.

Q. You can have tenderness?

A. Correct.

Q. The scarring can cause a feeling of tight banding?

MR. KOTT: Objection.

THE WITNESS: It could.

BY MS. MOORE:

Q. So that's something else you could see with and without mesh?

MR. KOTT: Objection.

THE WITNESS: More with mesh than without.

BY MS. MOORE:

Q. But my question is, you can still see banding with scarring and fibrosis?

MR. KOTT: Objection.

THE WITNESS: Yes.

BY MS. MOORE:

Q. Your plan was postmenopausal vaginal bleeding. What was your recommendation for her?

A. I did not have a recommendation for her.

Q. I'm sorry?

A. I did not have a recommendation for her. She already had a follow up with Dr. Winters.

Q. Were you aware that -- I think you referenced some low back pain?

A. Referenced super pubic pain. Did I reference that or did she say that and I recorded that?

Q. I believe you recorded that based on what she told you.

A. Yes.

Q. As we sit here today, you're not in a position to attribute the back pain to any particular aspect of the mesh?

MR. KOTT: Objection to the form.

BY MS. MOORE:

Q. Would that be fair to say?

A. I was just reporting what she told me.

Q. Right. And back pain can be caused by many things?

A. Correct.

Q. And someone with a history of anxiety and -- now that they are still presenting with that particular complaint, you're not attributing to her her ongoing of -- her ongoing anxiety to any specific thing with the mesh surgery, correct?

MR. KOTT: Objection to the form.

THE WITNESS: Her medical history was of depression.

BY MS. MOORE:

Q. If she had a history of anxiety dating back to 1989 --

A. I'm just going on her first visit to see me.

Q. Okay. So if she has an ongoing, preexisting history of anxiety dating to 1989, that could all be related to the same underlying anxiety, correct?

A. It could.

Q. She's got painful walking as she's telling you. Could that be related to lumbago, degenerative joint disease and poor conditioning?

A. It could be.

Q. So she's seeing a doctor, a chiropractor, in 2013 who is diagnosing that condition. Would you defer to him on what may be causing any problems with her pain, fullness in walking?

A. As it relates to his area of expertise, yes.

Q. So you're not opining today on what may be causing the pain in her legs or her painful walking, are you?

MR. KOTT: Object to the form.

THE WITNESS: I'm just stating what she told me as it relates to my physical exam.

BY MS. MOORE:

Q. I understand. But you're not opining on what caused this pain when she walks?

MR. KOTT: Object to form.

THE WITNESS: Not with what I am recording here.

BY MS. MOORE:

Q. Thank you. Also just for your

edification, she had a spinal stenosis in 2015. You weren't aware of that, correct?

A. I was not.

Q. Were you aware she had been diagnosed with fibromyalgia and Pickwickian syndrome?

A. No.

Q. What is Pickwickian syndrome?

MR. KOTT: Object to the form.

THE WITNESS: I don't know.

BY MS. MOORE:

Q. What is fibromyalgia?

A. It's a chronic inflammatory condition of which they have a fatigue, joint aches, and poor sleep.

Q. That may be causing or contributing to the fatigue she's feeling if she is, in fact, diagnosed with fibromyalgia?

A. I did not have that here so, I can't say.

Q. I think she's using a CPAP. Does a CPAP interfere with sexual function?

A. A CPAP?

Q. For sleep apnea.

A. No.

Q. It doesn't?

A. Depends on where you're having sex, I guess.

Q. If she notes that sleep problems disturb her sex life, you wouldn't be able to comment one way on the use of a CPAP, correct?

A. Well, if she doesn't sleep well, she's tired.

Q. Pardon?

A. If she's doesn't sleep well, she's tired. So if you're tired, interest goes down.

Q. All right. So I want to make sure -- you also talked about a vaginal discharge with odor. And we went through your records and you did not document vaginal discharge with odor until November 15th.

MR. KOTT: Of?

BY MS. MOORE:

Q. November 5th of 2015.

MR. KOTT: Thank you.

BY MS. MOORE:

Q. And there were ten other visits with no reference to vaginal discharge from November 19th, 2008 all the way up to November 15th, 2015?

MR. KOTT: Object to the form of that

statement.

BY MS. MOORE:

Q. Can you show us the basis for your opinion that she has vaginal discharge with odor, other than that November 5th, 2015 visit?

MS. MOORE: Let's go off the record.

VIDEOGRAPHER: Sure. The time is 6:48.

(Off the record.)

VIDEOGRAPHER: Back on the record.

BY MS. MOORE:

Q. We have taken a break, and I've given you an opportunity to look at your records. Have you been able to --

A. There was some bloody discharge on November 4th, 2008.

Q. And that was right after the surgery, right?

A. That was in the immediate post-op. You asked me if there was any recording of any discharge.

Q. Right. Other than something immediately in the postoperative period, do you have any documentation of vaginal discharge with odor?

MR. KOTT: In his records?

THE WITNESS: In my records, I don't have anything of those dates from there to there.

MS. MOORE: I'm going to conclude my questioning for now. Reserve the time that I have left until after Opposing Counsel has had a chance to ask questions. Thank you for your time.

MR. KOTT: How much time is left?

VIDEOGRAPHER: Nine minutes.

(Off the record.)

VIDEOGRAPHER: We are on.

EXAMINATION

BY MR. KOTT:

Q. Good evening.

A. Good evening.

Q. Dr. Goodyear, as you know I'm Joe Kott, and I represent the Plaintiff in this particular case. And this is your second phase of the depositions today; is that correct?

A. Correct.

Q. And this deposition was taken in reference to Ms. Taylor; is that correct?

A. That is correct.

(Exhibit No. 48 marked.)

Q. Okay. Doctor, I showed you a document moments ago, Bates number 48, excuse me, No. 48 exhibit number?

A. Correct.

Q. Doctor, we previously marked No. 30. With the exceptions of that set of documents being Bates numbered, are they identical to Exhibit No. 30?

A. Yes.

Q. Thank you very much. Doctor, in your prior deposition, we went through a number of documents, they are 24 -- they have been marked as 24, 25, 26, 27, 28, 29, 31, 32, 34, and 37. I'm going to show you these documents. Each one of them that have been marked and identified. Ask you to quickly look through them and then I have a solitary question for you regarding them.

A. Okay.

Q. Have you reviewed those?

A. I have.

Q. Doctor, are those the same documents numbered that we questioned you about during your prior deposition?

A. They were.

Q. And if I were to question you on those

documents again, that have been numbered and identified, would your testimony be the same in this deposition?

A. They would.

Q. Thank you.

MS. MOORE: Same objections I noted in the earlier deposition.

BY MR. KOTT:

Q. Doctor, you prepared a report dated November 5th, 2015. I believe you have that in front of you?

A. I do.

Q. And I believe that you were questioned earlier about having put in your report, which is exhibit number -- do you have the exhibit number on the report?

MR. KOTT: Let's go off the record.

VIDEOGRAPHER: We are off.

(Off the record.)

VIDEOGRAPHER: Go right ahead. Seven minutes.

MR. KOTT: Yes, sir.

BY MR. KOTT:

Q. Now, Doctor, if you would go to page two

of your report that's been prepared as an expert. There was a lengthy questioning regarding a statement that you made, "Patient presented 14 months later with repeat posterior erosion, incomplete bladder, urinary frequency, urinary incontinence, continued constipation which required splinting." Do you remember being questioned about that?

A. I do.

Q. Doctor, is it, in fact, that those symptoms when you look further into the medical records occurred sometime later than 14 months after the surgery?

A. That is correct.

Q. Okay. But they did occur based on your review of the additional medical records, correct?

MS. MOORE: Object to the form of the question.

THE WITNESS: Correct.

BY MR. KOTT:

Q. Now, there was also questioning regarding persistent vaginal bleeding, postoperative period following her October 2008 implant surgery to the current; is that correct?

A. That is correct.

Q. Doctor, if you would please look at your note from November 5th, 2015, when you did a history and physical. If you would look at the first -- and this is -- the exhibit number is --

A. No. 47.

Q. No. 47. When you look at the first sentence of the history and physical, second paragraph, would you read that into the record?

A. "Vaginal bleeding has persisted and worsened over the last two to three years."

Q. And that would be beginning in -- sometime in 2014 and 2013, in that area, two to three years?

A. Two to three years, could even be 2012.

Q. 2012. Again, in your report, expert report, when you said the patient had persistent complaint -- complained of persistent vaginal bleeding following the 2008 implant to current, is it more accurate to say that the persistent vaginal bleeding actually began sometime in 2012 or 2013?

MS. MOORE: Object to the form of the question. And leading.

THE WITNESS: Correct.

BY MR. KOTT:

Q. Okay. Now, Doctor, you also in -- you also reviewed records that weren't covered in your exam by Ms. Moore; is that correct?

A. That's correct.

Q. You reviewed records that were prepared by Dr. Winters, correct?

A. That is correct.

Q. And Dr. Winters' records according -- you reviewed these before preparing your report; is that correct?

MS. MOORE: Again, I'm going to object to the leading nature of the questions. This is your expert and you're not entitled to ask leading questions.

BY MR. KOTT:

Q. When did you prepare -- before preparing your report did you, in fact, review any medical records other than your own?

A. I did.

Q. Did you review Dr. Winters' records?

A. I did.

Q. Okay. And in reviewing Dr. Winters' records, did Dr. Winters recommend that she have

surgery for the problems -- for problems related to the mesh?

MS. MOORE: Object to the form of the question.

THE WITNESS: He did.

BY MR. KOTT:

Q. Okay. And when Dr. Winters did a history and physical exam and recorded those results, did his findings comport with your findings of your exam on March 25th -- excuse me, November 5th, 2015?

A. They did.

MS. MOORE: Same objection.

BY MR. KOTT:

Q. Doctor, are these records that you reviewed from Dr. Winters' records?

A. Yes.

MS. MOORE: Can I have a copy?

MS. KOTT: Yep.

BY MR. KOTT:

Q. And did Dr. Winters find that Ms. Taylor had recurrent prolapse?

MS. MOORE: Object to the form of the question. Leading.

MR. KOTT: I'll withdraw the question.

BY MR. KOTT:

Q. What were Dr. Winters' conclusions?

A. She is now re-experiencing symptoms of rectal bulging and pressure. That's a recurrence of the prolapse. She's also experiencing bladder bulging and occasional difficulty urinating. Insofar as her continence concern, she has mild leakage.

His physical exam found that she had a linear exposure approximately halfway up the posterior compartment. Linear granulation tissue. One can probably see the arm band of the Prolift. There is subvaginal area which is clearly mesh. Does not elicit much pain, but as you extend to the left side, the mesh arm does seem to elicit some discomfort.

He concludes that there's a painful scar band on the left, which corresponds to the Prolift arm. She has exposure four to five centimeters in length. She has this other mesh, which is palpable on exam, but unable to elicit symptoms today. She does have an anterior stage two cystocele.

Q. Okay. Now, Doctor, that -- does that -- we have already established, correct, that this

comports with your findings in November of '15?

MS. MOORE: Objection. Leading.

THE WITNESS: Correct.

BY MR. KOTT:

Q. Also, what you read as a description of the findings of Dr. Winters, are they in any way related to the site that you saw the hematoma way back in 2009, 2008?

MS. MOORE: Object to the form of the question. Leading.

THE WITNESS: Yes.

BY MR. KOTT:

Q. Okay. Now, are they into the arms now, do you have now issues into the arms of the mesh found by Dr. Winters?

MS. MOORE: Same objection.

THE WITNESS: As Dr. Winters described, yes.

BY MR. KOTT:

Q. Is that related to the hematoma?

A. That is not.

Q. Okay. And is the tenderness there that he described related to the hematoma that you saw?

A. It is not.

Q. Okay. Now, in fact, the hematoma, based on your records that we have, your own records, okay, it seems that that healed. All the symptomatology went away multiple times, correct?

A. Right.

MS. MOORE: Object to the form of the question and to leading. This is your expert, sir.

THE WITNESS: That is correct.

BY MR. KOTT:

Q. Well, I'm not going to use my time over that. That is correct that the hematoma resolved?

MS. MOORE: Same objection.

THE WITNESS: Yes.

BY MR. KOTT:

Q. So when a person develops mesh erosion secondary to issues with the mesh, okay, are they -- is the onset immediately after surgery or at some time later after the surgery?

MS. MOORE: Object to the form of the question. Calls for speculation.

THE WITNESS: Typically delayed.

BY MR. KOTT:

Q. And the fact that your examinations on

multiple occasions immediately after the surgery, after you tended to certain problems, seemed to resolve; is that fair to say?

MS. MOORE: Same objection.

THE WITNESS: Yes.

BY MR. KOTT:

Q. And is it also based on Dr. Winters and Dr. Galloway -- did you also review Dr. Galloway's report?

A. I did.

Q. Medical records?

A. Yes.

Q. And based on those two sets of records that you reviewed, that are on your list of documents you reviewed, did the more significant mesh issues develop later on in the course of Ms. Taylor's medical history?

MS. MOORE: Object to the form.

THE WITNESS: That is correct.

BY MR. KOTT:

Q. And that comports with issues with mesh, doesn't it?

MS. MOORE: Same objection. Leading.

THE WITNESS: That is correct.

MR. KOTT: I'm sorry, put your answer on the record.

THE WITNESS: That is correct.

MR. KOTT: I'm going to mark Dr. Winters' records as No. 49 in globo. And this runs from Bates number 49.

(Exhibit No. 49 marked.)

BY MR. KOTT:

Q. And also would you please look for me, Doctor, at Exhibit No. 50. And I'll purport to you -- these are Bates numbered one through 11. Tell me if you have seen those medical records before.

A. I have.

Q. And whose records are those?

A. These are Dr. Galloway.

Q. Does Dr. Galloway's examinations and conclusions comport with what you found in 2015 when you examined Ms. Taylor?

MS. MOORE: Object to the form of the question. And the leading nature of the question.

THE WITNESS: They do.

(Exhibit No. 50 marked.)

BY MR. KOTT:

Q. Thank you. Now, Doctor, let's go to your report, if we could. Well, I'll withdraw that question for now.

Doctor, let's go, please, to Exhibit No. 17, which it this final Prolift Surgeon's Resource Monograph.

A. Yes.

Q. Doctor, I would like you, please, again to focus your attention on paragraph eight where it says one to six percent --

A. Correct.

Q. -- erosion. You see that?

A. Yes. "Experiencing and avoiding hysterectomy when possible will reduce the rate to 1 to 6 percent."

Q. Okay. And that's a number that is in the document, it's clearly not a number you created, correct?

A. That's correct.

Q. Thank you. And also, clearly it occurs in approximately 3 to 17 percent is listed, erosion, you see that?

A. I do.

Q. That doesn't tell a doctor much at all, does it, that's such a wide range?

MS. MOORE: Object to the form of the question.

THE WITNESS: Correct. It's just a range.

MR. KOTT: Yeah.

MS. MOORE: Move to strike comments of Counsel.

MR. KOTT: I will do that, I apologize.

BY MR. KOTT:

Q. Okay. Let's go to your report, Doctor. If you would go to page four of your report.

VIDEOGRAPHER: Nine minutes.

MS. KOTT: Thirty minutes. We have 30 minutes.

VIDEOGRAPHER: I said he's got nine minutes.

MR. KOTT: Thank you. That means I've got 21 left.

MS. KOTT: Let's go off the record and figure out how much time I have left.

MR. KOTT: Yes, if we could. I think it's 21 minutes.

VIDEOGRAPHER: That's correct. But you

had 30 minutes.

MR. KOTT: Let's go to page four of your report.

MS. MOORE: We started at what time?

MR. KOTT: If we are going to talk, I've got to stop the clock.

MS. MOORE: You can stop the clock.

MR. KOTT: Stop the clock.

(Off the record.)

VIDEOGRAPHER: You are now, yes, sir.

BY MR. KOTT:

Q. On page four of your report, Expert Report of Nathan W. Goodyear, M.D. in the Taylor matter, correct?

A. Correct.

Q. You used a methodology to analyze this case?

A. That's correct.

Q. And that methodology goes from page four and part to page five, correct?

MS. MOORE: Object to the form of the question.

THE WITNESS: That is correct.

BY MR. KOTT:

Q. How far does the methodology go from, what pages?

A. Page four to page five.

Q. Thank you. Doctor, if I were to question you regarding the methodology that's used in this case, would your answers be the same as the responses you gave to me in the prior deposition earlier today?

A. Correct.

MS. MOORE: And --

MR. KOTT: Same objection.

MS. MOORE: Thank you, Counsel.

BY MR. KOTT:

Q. All right. Let's go next to the section where you register your opinions. Okay. And in this document, again, you have your opinions or to a reasonable degree of medical probability, is that recorded at the top of the page?

A. Correct.

Q. Can we also say that they are to a reasonable degree of medical certainty?

A. Correct.

Q. Thank you. What is the opinion you came

to in this case?

A. "Charlene Taylor's injuries were caused by the implanted Prolift and TVT-O devices."

Q. Okay. Now, the injuries that you feel were caused by these devices, are what?

MS. MOORE: Object to the form of the question. You may answer.

BY MR. KOTT:

Q. What injuries do you believe were caused by the device?

A. The vaginal mesh erosion.

Q. Any others?

A. The vaginal bleeding, the odor, the pelvic pain, the inguinal pain, the anxiety, the dyspareunia, and decrease sexual intercourse. The anxiety relationships related to that. The pain with movement. The decrease in physical activity, which compromised her metabolic issues and increased the weight gain.

Q. Thank you. Now, I -- you were asked questions about possibilities, other possibilities that could cause all of these problems earlier in this deposition; is that correct?

A. That's correct.

Q. Okay. When you remove mere possibilities, and go into probability, is it your opinion as expressed in item one?

MS. MOORE: Object to the form of the question.

THE WITNESS: It's probability and certainty, not possibility.

BY MR. KOTT:

Q. Okay. But to the things that you answered to earlier what it could have been or might have been, those were possibilities, correct?

A. Correct.

Q. And, Doctor, you list several paragraphs after item one to support your position; is that correct?

A. That is correct.

Q. Do you believe and swear here under oath that if you were to testify at this moment that you would cite that materials (sic) to the Court?

A. I would.

Q. Now, let's go to item number two. Would you please read your opinion on item number two?

A. "The Prolift and TVT-O devices implanted in Charlene Taylor were unreasonably dangerous due

to the lack of adequate warning."

Q. Now, Doctor, following that, you have several paragraphs supporting that opinion; is that correct?

A. That is correct.

Q. Doctor, if I were to take you through each one of those paragraphs here in this setting, would you testify under oath that those positions support your conclusion in opinion two?

MS. MOORE: Object to the form of the question.

THE WITNESS: Yes.

BY MR. KOTT:

Q. Item number three is a third opinion, Doctor. Would you read that third opinion into the record?

A. "The Prolift and TVT-O implanted in Charlene Taylor were unreasonably dangerous because they did not conform to the manufacturer's expressed warranties."

Q. Is that opinion, like the other two, to a reasonable degree of medical probability and, in fact, certainty?

MS. MOORE: Same objection.

THE WITNESS: Yes.

BY MR. KOTT:

Q. Okay. Now, Doctor, you go on after that on page eight and page nine to discuss what express warranties you reference in opinion three; is that correct?

A. That is correct.

Q. If I were to take you through each and every one of those items on pages eight and nine under the subtitle opinion three, would you testify under oath to the Court that those are the basis for your opinion as expressed in item number three?

MS. MOORE: Object to the form.

THE WITNESS: Correct.

BY MR. KOTT:

Q. Doctor, did the characteristics -- did the unreasonable characteristics cited -- sorry.

Were the unreasonably dangerous characteristics cited in number two and number three causative factors in the injuries sustained from the mesh by Ms. Taylor?

MS. MOORE: Object to the form of the question.

THE WITNESS: Yes.

BY MR. KOTT:

Q. Is that to a reasonable degree of medical probability?

A. Yes.

Q. Certainty?

A. Certainty, yes.

Q. Now, Doctor, were -- at the time you did this surgery, were there safer alternatives available to do -- to perform treatment in some fashion on Ms. Taylor other than using these products?

MS. MOORE: Object to the form.

THE WITNESS: There were.

BY MR. KOTT:

Q. And those were?

A. Observation, pessaries, posterior colporrhaphy, sacrospinous fixations, abdominal sacral colpopexy.

Q. Were there non-surgical treatments, too?

A. Observation, pessaries, yes.

Q. Now, Doctor, had you known about the unreasonably dangerous aspect of the products cited, both Prolift and TVT-O, used on Ms. Taylor, would you have used them at the time you performed surgery

on her?

MS. MOORE: Object to the form of the question.

THE WITNESS: I would not have used them.

MR. KOTT: Let's stop a minute, please, go off the record, so I can check with my esteemed colleague.

VIDEOGRAPHER: We are off.

(Off the record.)

VIDEOGRAPHER: We are back on the record.

BY MR. KOTT:

Q. Dr. Goodyear, I'm going to show you Exhibit No. 18. Just identify it quickly, please.

A. Gynecare Prolift IFU.

Q. Doctor, do you recall that document from your prior deposition this morning?

A. I do.

Q. Doctor, if I were to ask you questions about that document, the same questions I asked you this morning, would your answer -- if I did ask you any questions about that this morning, would your answers be the same?

MS. MOORE: Same objection.

THE WITNESS: They would be the same.

BY MR. KOTT:

Q. Thank you. Doctor, I have another document here, would you please read that? It is No. 19. Exhibit No. 19, I believe.

A. Gynecare TVT Obturator System.

Q. Right. Doctor, do you recall seeing that in your deposition this morning?

A. I do.

Q. Doctor, if I were to ask you the same questions that you were asked this morning in the deposition regarding that particular document, would your answers be the same?

MS. MOORE: Same objection.

THE WITNESS: They would.

BY MR. KOTT:

Q. Thank you. Now, Doctor, you were shown -- thank you -- Exhibit No. 40 during a portion of your deposition this evening. Do you recall this document?

A. I do recall that.

MR. KOTT: I have another copy of this document somewhere.

MS. KOTT: It's an exhibit. That's our copy. Off the record, please.

VIDEOGRAPHER: We are off.

(Off the record.)

VIDEOGRAPHER: We are on.

BY MR. KOTT:

Q. Doctor, if you would please go to page five of deposition 40 -- Deposition Exhibit No. 40.

A. I'm there.

Q. You saw this document earlier today?

A. I did.

Q. Okay. The -- and we are on page five of that document. Are you there, it's Bates 12013?

A. Yes.

Q. Would you read into the record that paragraph that starts in conclusion?

A. "In conclusion, while this study did not" --

Q. Slow down. Just read it slow.

A. "In conclusion, while this study did not meet the stringent predefined statistical criteria in terms of demonstrating an incidence of prolapse recurrence at 12 months or below 20 percent, the absolute rate of 18.4 percent demonstrates the invaluable role of TVM in treating patients with vaginal prolapse in terms of reasonable success

rates and a lower rate of recurrence, re, operation compared to other published studies."

Q. That's good. You can stop.

Doctor, in the conclusion you just read, Ethicon reports in this document, this study, that it did not meet the requirements -- the stringent requirements that they had predefined with reference to recurrence; is that correct?

MS. MOORE: Object to the form of the question.

THE WITNESS: Correct.

BY MR. KOTT:

Q. Okay. You were never shown this document by Ethicon prior to the surgeries you performed on your clients, were you?

MS. MOORE: Same objection.

THE WITNESS: No.

BY MR. KOTT:

Q. Would you please go to page 48 of the same document?

A. I'm there.

Q. Yes, sir. You had never seen this document before today; is that correct? Excuse me.

You hadn't seen this document before the

institution of the litigation? Thank you. I'm tired.

A. Correct.

MS. MOORE: Object to the form.

Q. Is that correct?

A. Correct.

Q. So no one ever produced this document to you when they were training you to use this product?

A. That's correct.

MS. MOORE: Same objection.

Q. Now, Doctor, when you inquired to the manufacturer's rep about whether you were accurate in the 3 to 5 percent in your consent forms -- you did that, correct?

A. Correct.

Q. Did he at any point in time say, you know, you really ought to go take a look at this study that was done in 2006, because they report failure rate of 10 percent?

MS. MOORE: Object to the form of the question.

THE WITNESS: He did not.

BY MR. KOTT:

Q. Did anybody ever come tell you that from

Ethicon?

A. No.

Q. Or Johnson & Johnson?

A. No.

Q. You would have liked to have known that?

A. That would have been important in the decision making, yes.

MS. MOORE: Object to the form of the question.

Q. It would have been important in your decision whether to use this product or not, correct?

A. I would not have used it.

MS. KOTT: I just want to attach --

MR. KOTT: Okay. This is the same thing. The cross notice. This is Deposition Cross Notice No. 51.

And can we go off the record for a moment, please? And can you tell me how much time I have?

VIDEOGRAPHER: One minute.

(Exhibit No. 51 marked.)

(Off the record.)

VIDEOGRAPHER: We are back on the record.

BY MR. KOTT:

Q. Now, Doctor, you were asked at length about the severity -- potential severity of pelvic organ prolapse. Do you recall that?

A. I do.

Q. How severe it can be?

A. Correct.

Q. Not all the patients that you see are that severe?

A. That's correct.

Q. Some of these cases are mild to moderate cases, correct?

A. That's correct.

Q. Thank you. I don't mean to do that. Thank you. I really don't.

You were examined for three hours prior -- no, not three. Three hours, nine minutes earlier today by Ms. Moore, correct?

A. Correct.

Q. During the course of that examination, in all the documents she showed you and all the questions that were asked to you, did any of those questions change the opinions that you expressed in your report on Ms. Taylor?

A. No.

MS. MOORE: Object to the form. That's it. Time.

MR. KOTT: What time is it? It's done?

VIDEOGRAPHER: It's done.

MR. KOTT: I think the Judge would let me have one more question.

MS. MOORE: I think the Judge would let you have one.

MR. KOTT: Thank you. We are done.

MS. MOORE: I have ten minutes.

MR. KOTT: Why do you have ten minutes?

MS. KOTT: She reserved nine.

MR. KOTT: She reserved nine, so why do you get ten? Because the Judge would let you have ten, right? If you take ten minutes --

MS. MOORE: Can we just stay?

MR. KOTT: You want -- you just come over.

VIDEOGRAPHER: Off the record.

(Off the record.)

VIDEOGRAPHER: We are on the record.

EXAMINATION

BY MS. MOORE:

Q. All right. The light at the end of the

tunnel, Doctor.

You were asked about the time period in which you treated Ms. Taylor, and asked questions about that, perhaps some of the complications that she is experiencing would not appear until later on after the surgery, correct?

A. Correct.

Q. And you treated her from June of 2008 until around October of 2011, correct?

A. Correct.

Q. About three years, a little more than three years?

A. 2008 to October -- correct.

Q. And during that time, we saw some improvement in her condition, correct?

A. What would you define as her condition?

Q. You defined good support with respect to the pelvic wall?

A. Pelvic floor.

Q. Pelvic floor?

A. Correct.

Q. You did not see evidence of vaginal bleeding except for post-op -- during the post-op period?

A. Correct.

Q. You did not see evidence of the vaginal discharge or odor?

A. Correct.

Q. You did not see evidence of the urinary urgency and other urinary problems?

A. That would be symptoms, and I did see those in 2015.

Q. You're right in 2015. But, again, I'm staying within the window of June 2008 to October 2011.

A. Correct.

Q. And she did not complain to you of back pain?

A. Correct.

Q. No complaints of leg pain?

A. Correct.

Q. No complaints of dyspareunia?

A. Correct.

Q. And you did see some evidence of the mesh, correct?

A. On numerous occasions, correct.

Q. That you trimmed as appropriate?

A. Correct.

Q. And then she returns to see you in 2015 with more significant complications, correct?
A. Correct.
Q. And at this point in time she is now involved in litigation, correct?
A. Correct.
Q. And since she has retained the lawyer and filed a lawsuit, she has at least reported to you that she's having more complications?
A. The complications she states are since my last visit with her in 2011.
Q. Right. And during that time, she's retained a lawyer and filed a lawsuit, correct?
MR. KOTT: Object to the form.
THE WITNESS: Correct, correct.
BY MS. MOORE:
Q. So as we sit here today, you know, you talked a lot about your methodology and all, you can't rule out what portions, if any, of Ms. Taylor's complaints may be partly or whole or in whole related to the litigation concerns she has?
MR. KOTT: Object to the form.
THE WITNESS: You're asking me to jump in her head. I cannot do that.

BY MS. MOORE:

Q. I'm asking you that -- strike that.

She did not have significant complaints related to the mesh until after she retained a lawyer and filed a lawsuit against Ethicon and returned to you in 2015, correct?

MR. KOTT: Object to the form.

THE WITNESS: I don't know that, because the last time I saw her was in 2011.

BY MS. MOORE:

Q. But during that window, three plus years, she did not have significant complaints?

MR. KOTT: Object to the form.

THE WITNESS: I did not see her during that time frame, so I do not know.

BY MS. MOORE:

Q. You did not see her from June 2008 to October --

A. I thought you said 2011 to 2015.

Q. Okay. If I did, I misspoke and I apologize.

During the June 2008 to October 2011 time period that you saw her, three plus years, she did not have significant complaints related to the mesh,

correct?

A. Other than the erosion.

Q. Other than the erosion?

A. Correct.

Q. You treated that appropriately inpatient, correct?

A. Correct.

Q. You did the trimmings? She was able to leave that day?

A. Correct.

Q. Did not go under general anesthesia?

A. Correct.

Q. And reported to you that she was doing better?

A. Correct.

Q. The erosion -- we can debate the risk of erosion that was prevalent during the time you treated Ms. Taylor, and during the time you did her surgery, but you will acknowledge that you knew it was a risk?

A. What was a risk?

Q. The risk of erosion.

A. With the surgery?

Q. Yes, sir.

A. Yes.

Q. Okay. So whether the risk was 10 percent or 15 percent, it was a risk you were aware of and you took?

MR. KOTT: Object to the form.

BY MS. MOORE:

Q. Correct?

A. Correct.

Q. And, in fact, your own experience was a higher risk, higher than even what we have seen in any documents today, correct?

A. Correct.

MS. KOTT: You're over.

MS. MOORE: Am I? The Judge would allow me --

MR. KOTT: One question. One question.

THE WITNESS: I'm not sure my wife would.

MS. MOORE: One question. Do I really have to pick? I'm just kidding.

MR. KOTT: I don't think you can ask one question.

MS. MOORE: It's hard. I have to admit, you guys are really ruining my day.

BY MS. MOORE:

Q. Doctor, the site of the hematoma, even if healed, is going to be at an increased risk of erosion because the tissue in that area is not normal?

MR. KOTT: Object to the form.

THE WITNESS: Correct. It's a blood clot.

MS. MOORE: Okay. No further questions. Thank you.

MR. KOTT: Thank you.

MS. MOORE: Good night.

VIDEOGRAPHER: You want me to go off the record?

MS. CAPODICE: Let's go off the record first and then let's go to the exhibits and then go back on and specify. Is that okay?

MR. KOTT: Yes.

(Deposition concluded at 7:39 p.m.)

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ACKNOWLEDGMENT OF DEPONENT

I,_____, do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

NATHAN W. GOODYEAR, M.D. DATE

Subscribed and sworn
to before me this
_____ day of _____, 20____.
My commission expires:_____

_____

Notary Public

REPORTER CERTIFICATE

STATE OF TENNESSEE

COUNTY OF KNOX

I, Michele Faconti, RPR, Licensed Court Reporter, LCR #667, in and for the State of Tennessee, do hereby certify that the deposition of Nathan W. Goodyear, M.D., taken on March 3rd, 2016, was reported by me and that the foregoing transcript, pages 1 through 166, inclusive, is a true and accurate record to the best of my knowledge, skills and ability.

I further certify that I am not related to, nor an employee or counsel of any of the parties to the action as defined under T.C.A. Section 24-9-136, nor am I financially interested in the outcome of this case. Reading and signing not waived.

In witness thereof, I have hereunto set my hand on this 14th day of March, 2016.

_____

Michele Faconti: 03/14/16 22:32:01 AM; Knoxville Tennessee; TN LCR 667 expires: 6-30-2016